



**Educational Assessment
and
Student Support Clinic**

1705 E. Campus Center Drive
Rooms 377-387
Salt Lake City, UT 84112
Phone: 801-581-6068
Fax: 801-581-5566

CLINICAL INTERVIEW FORM

For Adults:

Client's Name _____

Date _____

Person Completing Form (if other than Client) _____

Please send all mail correspondence to:

ATTN:
Department of Educational Psychology
1721 E. Campus Center Drive
SAEC 3220
Salt Lake City, UT 84112



Educational Assessment and Student Support Clinic

Client Information Form

Name _____

Date _____

Date of Birth _____

Referred by _____

Client:

Spouse:

Name _____

Name _____

Street Address _____

Street Address _____

City _____

City _____

State _____ Zip _____

State _____ Zip _____

Home Phone _____

Home Phone _____

Cell/Work Phone _____

Cell/Work Phone _____

Date of Birth _____

Date of Birth _____

Marital Status _____

Marital Status _____

Education _____

Education _____

Occupation _____

Occupation _____

Employer _____

Employer _____

Members of household:

Name _____ Age _____ Sex _____ Relationship _____

Name _____ Age _____ Sex _____ Relationship _____

Name _____ Age _____ Sex _____ Relationship _____

Name _____ Age _____ Sex _____ Relationship _____

Ethnicity: (check all that apply) Caucasian Hispanic/Latino(a) African American

Native American Asian _____ Other

Are you currently taking medication?

Drug _____ Dose _____ Purpose _____ Prescribed by _____

Drug _____ Dose _____ Purpose _____ Prescribed by _____

Reason for currently seeking services:

Previous therapy/evaluation: Yes/No (if yes, where/when?) _____

Clinic Services:

The Educational Assessment and Student Support Clinic of the Department of Educational Psychology at the University of Utah serves children, adolescents, and adults and their families. The Clinic works with schools and other agencies such as Primary Children's Medical Center to provide psychological, neuropsychological, and psychoeducational assessment, consultation, and intervention in the community by graduate students and University faculty.

The Clinic offers specialized assessment in specific areas, such as neuropsychological assessment of children, adolescents, and adults with learning disabilities, head trauma, attention-deficit/hyperactivity disorder (ADHD), and autism. Psychological assessment of children and adolescents with mood and behavior disorders is also offered. Interventions available include individual therapy with children and adolescents; parent training; group and individual social skills training; and academic planning and consultation with the schools regarding a student's educational plan.

The following faculty hold clinic positions:

Janiece Pompa, Ph. D., Clinic Director
Elaine Clark, Ph. D., Department Chair
William Jenson, Ph. D., Supervisor
Daniel Olympia, Ph. D., Supervisor
Alicia Hoerner, Ph. D., Supervisor

Clinical Interview Form:

Please complete this form prior to your appointment. Although it is lengthy, it is important to obtain a clear and accurate developmental history of each client in order to understand his or her learning ability and behavior. It will also help us in formulating a remediation plan for him or her.

*(Clients who have completed the intake packet for the Neurobehavioral Clinic at Primary Children's Medical Center may substitute that questionnaire for this one. Please provide a copy to the clinician prior to your appointment.)

In addition, it is very helpful to bring the following to your appointment:

- Medical records of treatment and doctor's visits with regard to illness/injury. Especially important are reports from neurologists and neurosurgeons; reports of CT/MRI/EEGs of the brain; emergency room/EMT reports; highway patrol /police reports (if there was an accident).
- School grade report cards, transcripts, including results of standardized testing (SAT, CAT, Iowa tests, etc.)
- Reports of previous psychological/neuropsychological evaluation (including IQ or academic testing administered by the school or other agencies).

Please do not forget to bring these materials and your completed form to your first appointment.

Referral Questions:

Describe the reasons for referral. Please include specific behaviors or problems that you would like help with.

What services or interventions have been previously performed (if any)?

Family History:

Please indicate any family members on either side who have had any of the following:

MEDICAL PROBLEMS	MOTHER'S SIDE	FATHER'S SIDE
Intellectual disability		
Learning disabilities/problems		
Hyperactivity/attention problems		
Speech/language problems		
Seizures		
Headaches		
Genetic disorders		
Miscarriages		
Multiple Sclerosis		
Tourette's syndrome		
Thyroid problems		
Other medical problems		

PSYCHIATRIC PROBLEMS	MOTHER'S SIDE	FATHER'S SIDE
Depression/suicide		
Bipolar disorder (Manic-Depression)		
Anxiety disorder		
Panic attacks		
Obsessive-compulsive disorder		
Phobias and fears		
Autism spectrum disorder		
Schizophrenia		
Hallucinations		
Alcohol/drug abuse (specify)		
"Nervous breakdowns"		
Other		

Pregnancy, Delivery and Birth:

Were there any problems during your mother's pregnancy with you or at your birth? If so, please describe:

Developmental History:

Were there any problems during your development, such as delayed walking, talking, or problems relating to others? If so, please describe:

School History:

Entered school at age _____. Describe your grades and behavior in elementary school:

Describe your grades and behavior in junior high school:

Describe your grades and behavior in high school:

Describe your academic performance in college or trade school:

Describe your performance on the job:

Describe your talents or skills:

Date of the incident: _____

Did you suffer loss of consciousness? _____ For how long? _____

Did you have amnesia of events before the incident? _____ After? _____

Did you remember the incident itself? _____

Were you treated by a doctor? _____ Hospitalized? _____

Describe the length and course of the hospitalization:

Indicate the neurodiagnostic procedures performed:

- CT or brain scan _____
- MRI of brain _____
- EEG _____
- Lumbar puncture (spinal tap) _____
- Other (PET, SPECT, etc.) _____

Physician(s) currently caring for you?

Please indicate and describe whether you currently or in the past have experienced or complained of the symptoms listed below. Please indicate whether the problem has been resolved or is ongoing.

Physical Symptoms:

- Sensitivity to noise _____
- Sensitivity to light _____
- Ringing in the ears _____
- Dizziness _____
- Nausea/vomiting _____
- Blurred vision _____
- Double vision _____
- Hearing problems _____
- Problems with taste or smell _____
- Numbness or tingling in extremities _____
- Sleep problems _____

- Fatigue _____

Psychological Symptoms:

- Depression _____
- Mood swings _____
- Irritability _____
- Anger _____
- Aggression _____
- Low frustration tolerance _____
- Can't handle stress _____
- Anxiety _____
- Panic attacks _____
- Paranoia _____
- Hate to be in crowds _____
- Social withdrawal/social problems _____
- Hallucinations _____
- Personality change _____
- Difficulty with change _____

Cognitive Symptoms:

Memory

- Poor short-term memory _____
- Poor long-term memory _____

Reasoning

- Reasoning problems _____
- Take things too literally _____
- Difficulty understanding consequences of actions _____

Language

- Problems understanding what others say _____
- Say "what" a lot _____
- Need frequent repetition to understand _____
- Do not listen _____
- Can't follow a 3-step command _____
- Trouble expressing self verbally _____

- Talk too much or too little _____
- Problems finding the right word to say _____
- Stutter _____

Visuospatial

- Trouble with visual tasks (e.g., puzzles, games, etc.) _____
- Poor drawing ability _____
- Poor penmanship _____
- Get lost frequently _____
- Have trouble with directions _____

Other

- Attention problems _____
- No concept of time _____
- Clumsy, poor motor skills _____
- Drop in school performance (which subjects and when?) _____

Additional information:

Please provide any other information or describe any other concerns that have not been covered in this questionnaire

Psychological Services – psychotherapy/interventions

Psychological interventions, including psychotherapy, are not easy to describe in a few general statements. Effective treatment depends upon the particular problems you may be experiencing, as well as personality factors and establishing a good therapist-client alliance. In an important respect, psychotherapy is dissimilar to visiting a physician in that it calls for more active effort on your part. For therapy to be most successful, you will have to work on the things we talk about during the sessions and at home.

Psychological treatment includes potential for some risk as well as benefits. Since therapy may involve discussing unpleasant aspects of your life, you may experience uncomfortable feelings that may be temporarily discomfoting. On the other hand, psychological treatment has been known to produce many benefits such as a reduction in distress, solutions to specific problems, and better relationships. There can be no guarantees of what you will experience. The University of Utah Educational Assessment and Student Support Clinic attempts to minimize risks by providing well-supervised and trained therapists and by conducting frequent evaluations of client progress/status.

The first few sessions will involve an evaluation of your needs. By the end of this evaluation period, your therapist will be able to offer you an initial impression of your needs and a plan for what treatment might include, if you decide to continue with therapy. If you ever have any questions about procedures, you should discuss them whenever they arise.

The University of Utah Educational Assessment and Student Support Clinic hours are by arrangement. The clinic does not provide full-time telephone coverage during working hours, and you may be asked to leave a message for the therapist. Your therapist will make every effort to return your call as soon as possible. If you are difficult to reach, please leave some times you may be available or an alternative phone number which you can be reached. The clinic does not provide emergency services (see Emergency Care and Crisis Situations).

Psychological Services – psychological/neuropsychological/psychoeducational evaluations.

Evaluations are designed to provide benefits such as an accurate description of client, cognitive, intellectual and psychological strengths and weaknesses, treatment planning, school and vocational planning. However, as with psychotherapy, evaluations include potential risks as well as benefits, as previously described. Evaluations may involve several appointments of several hours each, and generally consist of interviews with the client, administration of tests and/or questionnaires, and, when indicated, interviews with school personnel, physicians or other individuals who can provide helpful information to aid in the evaluation. Your written consent will be necessary to authorize these contacts. Following the completion of the evaluation, a session will be held with you and your clinician to discuss the results. Due to supervision requirements, it may take several weeks for your clinician to produce a written report of the evaluation. **If a report must be written by a certain date, please discuss this with your clinician well in advance.** Every effort will be made to make sure that reports are written and disseminated in a timely manner.

Confidentiality

Utah law protects the privacy of communications between a client and a psychologist. Every effort will be made to keep your evaluation and treatment strictly confidential. In most situations, the clinic will only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements.

In the following situations, no authorization is required:

- a) Clinical information about your case may be shared fully within the University of Utah Educational Assessment and Student Support Clinic by the students enrolled in the clinic practicum and faculty for educational and therapeutic purposes. If clinical staff presents case information at case conferences, the information will be disguised so it will be impossible to link the information to you or your family.
- b) Personal information is also shared for clinic administrative purposes such as scheduling and quality assurance. Clinic files are also available to program site visitors. Data contained in your file are available for archival research (i.e. reviews of records to describe clinic referrals, outcomes, and trends) as long as your identity cannot be linked to the data used. All staff members have been given training about protecting your privacy and have agreed not to disclose any information without authorization or approval of the Clinic Director in mandated reporting situations (see Limits of Confidentiality).
- c) On occasion, your clinician may find it helpful to consult with another health or mental health professional. During such a consultation, every effort is made to avoid revealing the identity of the client. The other professional is legally bound to keep the information confidential. If you don't object, it is our policy to tell you about such consultations only if it is important to you and your therapist working together. All consultations are noted in the client's clinic record.
- d) You should be aware that from time to time the clinic may establish a contract with an outside agency to perform services, and protected information may be shared with them. As required by HIPAA, the clinic will establish a formal business associate contract in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide a blank copy of this contract. Disclosures to collect overdue fees are discussed elsewhere in this agreement.

Limits of Confidentiality

There are unusual situations where the clinic may be required or permitted to disclose information without your authorization. These include:

- a) If the clinic has knowledge, evidence, or reasonable concern regarding the abuse or neglect of a child, elderly person, or disabled person, it is required to file a report with the appropriate agency. Once such a report is filed, we may be required to provide additional information.
- b) If a client communicates an explicit threat of serious physical harm to a clearly identifiable victim or victims, and has the apparent intent and ability to carry out such a threat, the clinic may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, and/or seeking hospitalization for the client.
- c) If we believe that there is an imminent risk that a client will physically harm himself or herself, we will also take protective actions (See Emergency Care and Crisis Situations).
- d) Although courts have recognized a therapist-client privilege, there may be circumstances in which a court would order the clinic to disclose personal health or treatment information. We also may be required to provide information about court-ordered evaluations or treatments. If you are involved in, or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order the clinic to disclose information.
- e) The clinic is required to provide information requested by a legal guardian of a minor child, including a non-custodial parent.
- f) If a government agency is requesting information for health oversight activities or to prevent terrorism (Patriot Act), the clinic may be required to provide it.
- g) If a client files a complaint or lawsuit against the clinic or professional staff, the clinic may disclose relevant information regarding the client in order to defend itself. If any of these situations were to arise, the clinic would make every effort to fully discuss it with you before taking action, and would limit disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions you have with us now or in the future. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

Emergency Care and Crisis Situations

The University of Utah Educational Assessment and Student Support Clinic is not able to provide emergency services or psychiatric medications. Individuals, who because of psychiatric difficulties need substantial case management, ongoing medication adjustments, and/or emergency clinician access, are generally not appropriate for a training clinic. Such clients may be seen at the clinic when their situation is more stable.

University of Utah Educational Assessment and Student Support Clinic clients who are experiencing a crisis are encouraged to discuss this with their therapist as soon as possible so that a crisis plan can be developed. A crisis may be generally defined as a situation or period in which the person's usual coping resources fail and they experience a state of psychological disequilibrium in which they may be at risk for impulsive or harmful behavior. There are many examples of crisis situations, which may include:

A client who is struggling with suicidal ideation, a teenager who under distress runs away from home, a psychotic client who experiences severe symptoms such as hallucinations or paranoia because they have discontinued medications, and an alcohol/drug client who relapses to uncontrolled drug use with danger of overdose or serious harm. Such clients may or may not constitute an imminent danger to themselves or others; nevertheless, sometimes a judgment must be made to protect the client.

The policy of the University of Utah Educational Assessment and Student Support Clinic to which you consent as a client is to provide conservative treatment during a crisis situation. Your clinician would work with you to establish a plan to restore normal functioning as soon as possible. In addition to coping skills and possible environmental changes, this may include consultation with your physician, or if necessary, a family member or significant others. If you are student living in university housing, it may mean letting appropriate university officials know of your situation.

The clinic may divulge your client status and the minimal treatment information necessary to protect you during a crisis period. The need for such an action will be discussed with you until the crisis is over or your care has been successfully transferred to another mental health provider or treatment program. This crisis policy requires that you trust in our professional judgment to balance risks with your rights to confidentiality. The crisis policy is consistent with a training clinic that supervises graduate trainees.

The clinic instructs clients who cannot reach us and are having an emergency to contact a local hospital emergency room or other community resources directly such as University Neuropsychiatric Institute (801) 583-2500, or Valley Mental Health (801) 261-1442.

Professional Records and Client Rights

The laws and standards of the psychology profession require that the clinic keep Protected Health Information (PHI) about you in your clinical record. Generally, you may examine and/or receive a copy of your clinical record, if you request it in writing. There are a few exceptions to the access: 1) some unusual circumstances described above, 2) when the record makes reference to another person (other than a health care provider) and we believe that access is reasonably likely to cause substantial harm to that person, or 3) where information has been supplied confidentially by others. Also, the clinic will not release copyrighted test information or raw data to you or your representative without a subpoena. Because these are professional records, they can be misinterpreted. For this reason, the clinic recommends that you initially review them in the presence of your therapist, or have them forwarded to another mental health professional so you can discuss the contents. The University of Utah Educational Assessment and Student Support Clinic keeps no additional notes (sometimes called psychotherapy or progress notes) beyond the clinical record. In most circumstances, the clinic is allowed to charge a copying fee for

reproducing your records. If the clinic refuses your request for access to your records, you have the right to a review of this decision (except for information supplied confidentially by others), which the Clinic Director will discuss with you upon request.

HIPAA provides you with several new or expanded rights with regard to your clinical records and disclosures of protected health information. These rights include requesting that the clinic amend your record; requesting restrictions on what information from your clinical records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures were sent; having any complaints you make about clinic policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. Your therapist or the Clinic Director will be happy to discuss any of these rights with you.

Research

The psychology clinic also provides a site for clinical research conducted by graduate students and the clinical faculty. Clients may be approached for participation in clinical research studies conducted by University of Utah Educational Assessment and Student Support Clinic and/or their graduate students who have received prior approval for the specific study from the University of Utah Human Subjects Committee (Institutional Review Board). Prior to any research participation, a separate informed consent fully explaining the study must be provided, and the individual can choose either to participate or not to participate. Any client who decides not to participate in a study will not be penalized (i.e. services to which they are ordinarily entitled through EASSC will not be withheld if you choose not to participate in any research study).

Fees, Billing, and Payment Policy

The University of Utah Educational Assessment and Student Support Clinic charges reduced fees. If your situation is appropriate for the clinic and you decide to seek services, you will be asked to sign a fee contract with specific fee arrangements. The fee schedule is as follows:

Adult Psychological/Psychoeducational evaluation: \$350
Neuropsychological evaluation: \$500
Psychotherapy/Intervention: \$20/hour

Payment is due at the time of service. The clinic does not bill or accept insurance payments. If you are unable to afford these fees, you may petition the Clinic Director for reduced fees or to set up a payment plan.

Summary of Client Responsibilities

As a client of the University of Utah Educational Assessment and Student Support Clinic, you agree to:

1. Keep regular appointments and actively participate in your treatment.
2. Attempt any therapeutic assignments you agree to perform.
3. Make a commitment to living and using clinic and community resources to solve difficulties. You will be asked to agree to disclose to the therapist feelings of being in crisis and/or suicidal, to work with the therapist to develop a crisis plan, and to give the clinic discretion regarding needed disclosures in a crisis situation.
4. Not to come to the clinic under the influence of alcohol or other drugs. If you were to appear intoxicated, the clinician will cancel the session and request that the intoxicated person refrain from driving. Failure to do so will require a DUI report.
5. Never bring a weapon of any sort to the clinic.
6. Ask your therapist questions right away if you are uncertain about your evaluation, therapeutic process or any clinic policy.
7. Pay agreed upon evaluation and treatment fees or make arrangements to do so.

Informed Consent

Your signature below indicates that you have read this agreement and agree to its terms. These matters have been explained to you and you fully and freely give consent to receive clinic evaluation and/or treatment services.

Name of Client(s) please print

Signature of Client

Date

Signature of Client

Date

Witnessed by

Date



**Educational Assessment
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Videotape Agreement

Name of Client _____

I, _____, authorize permission to the University of Utah Educational Assessment and Student Support Clinic (EASSC) to videotape me for the purpose of professional education, supervision, treatment and research as part of the service agreement.

The video agreement states:

1. The client consents to the use of videotape to be taken in the office of the EASSC during the course of individual treatment.
2. The videotape will be used solely in the interest of the advancement of mental health programs and services for the purpose of professional education, supervision, treatment and research. The videotape will not be used for any other purpose.
3. EASSC agrees not to use, or permit the use of the name of the person named above in connection with any direct or indirect use of exhibition of the videotape for any use other than set forth in the service agreement.
4. EASSC is the sole owner of all rights in and to the videotape.
5. There shall be no financial compensation for the use of such videotape.

Client signature

Date

Clinician signature

Supervisor signature



**Educational Assessment
and
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Notice of Privacy Practices
Brief Version

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy:

The University of Utah Educational Assessment and Student Support Clinic is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the full, legally required Notice of Privacy Practices (NPP). Please ask your clinician if you would like a copy of NPP for your records.

We will use the information about your health, which we get from you or from others mainly to provide you with treatment, to document payment for services, and for some other business activities, which are called, in the law, health care operations. After you have read this NPP we will ask you to sign a Consent Form to let us use and share your information. Your signature is necessary for us to serve you.

If you or the Clinic want to use or disclose (send, share, release) your information for any other purposes your clinician will discuss this with you and ask you to sign an Authorization form to allow this.

We will keep your health information private but there are some times when the laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization, which is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a court requires us to do so.
4. For Workers Compensation and similar benefit programs.

Additional situations, which are less common, are described in the longer version of NPP.

Your rights regarding your health information:

1. You can ask your clinician to communicate with you about health and related issues in a particular way or at a certain place, which is more private for you. For example, you can ask him/her to call you at home, and not at work to schedule or cancel an appointment. He/she will try his/her best to accommodate your request.
2. You have the right to ask your clinician to limit what he/she tells people involved in your care or the payment for your care, such as family members and friends. While he/she doesn't have to agree to your request, if he/she does agree, he/she will keep this agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you in the routine case notes and billing records. You can get a copy of these records but we may charge you for this service.
4. If you believe the information in your records is incorrect or missing important information, you can ask your clinician to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to him/her. You must tell him/her the reasons you want to make changes.
5. You have the right to a copy of this notice. If we change this NPP we will post the new version in the waiting area. You can request a copy of the NPP from your clinician.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the Clinic Director, Dr. Janiece Pompa, and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care your clinician provides to you in any way.

If you have any questions regarding this notice or the health information privacy policies, please contact:

Dr. Janiece Pompa
janiece.pompa@utah.edu

The effective date of this notice is September 18, 2008

My clinician has discussed the health information privacy policies with me.

Signature

Date



**Educational Assessment
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Client Acknowledgement of Receipt of Notice of Privacy Practices

(You may refuse to sign this acknowledgement)

I, _____, have received a copy of the Notice of Privacy Practices from _____.

Name

Signature

Date

For Office Use Only

We have made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices. Acknowledgement could not be obtained for the following reason(s):

- Patient/Individual refused to sign (Date of refusal) _____
- Communication barriers prohibited obtaining an acknowledgement
- An emergency situation prevented us from obtaining an acknowledgement
- Other _____

An attempt was made by: _____ Date: _____

Explain: _____