Peggy Hill, LCSW, BCN Board Certified in Neurofeedback
Windward Biofeedback Associates
319B Kihapai Street
Kailua, Hi 96734
Tel. (808) 781-3007

HIPAA NOTICE OF PRIVACY PRACTICE

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

PEGGY HILL AND WINDWARD BIOFEEDBACK ASSOCIATES, located at 319B Kihapai Street, Kailua, Hi, 96734, respect your privacy and are committed to maintain and protect the confidentiality of your health information without interfering with your access to quality health care. We are required by federal law to protect and maintain the privacy of your "Protected Health Information" or "PHI" and to provide you with notice of our legal duties and privacy practices. Your PHI is any information generated, or collected by this office, such as demographic information and information relating to your past, present, or future physical mental health or condition. The types of documents containing your PHI include clinical records, billing invoices, and payment forms, and may also include videotapes and other documents, that are stored in paper, electronic, or in some other form.

This notice describes your rights as well as how we may use and disclose your PHI to the minimum reasonably needed for treatment, payment, health care operations, and other purposes permitted or required by law. This office reserves the right to make changes in our privacy practices regarding your PHI, and will provide you with notice of any changes. Except as described in this notice, this office will not use or disclose your **PHI** without your written authorization.

You Have The Following Rights With Respect To Your PHI:

Obtain a paper copy of this notice upon request. You may request a copy of this notice at any time by calling our office at (808) 781-3007, or writing us at 319B Kihapai Street, Kailua, Hi, 96734

Request restrictions on the use and disclosure of your PHI for treatment, payments or health care operations purposes or notification purposes.

Limit communications of PHI by alternative means or alternative locations. You have the right to receive confidential communications about your own health information by alternative means or at alternative locations. This means that you may, for example, designate that we contact you only via e-mail, or at work rather than at home. To limit communications, please submit a written request to this office and specify how, or when, you would like to be contacted. We will accommodate all reasonable requests.

Access and copy your PHI. You have the right to inspect and copy any health information about you other than psychotherapy notes, information compiled in anticipation of or for use in civil, criminal or administrative proceedings, and certain information that is governed by the Clinical Laboratory Improvement Act. To arrange for access to your records, or to receive a copy of your records, please submit a written request to this office. A fee may be charged for the costs of copying, mailing, or other supplies that are necessary to grant each request.

Despite your general right to access your PHI, access may be denied in some limited circumstances. For example, access may be denied if you are a participant in a research program that is still in progress. Access to information that was obtained from someone other than a health care provider under a promise of confidentiality can be denied if allowing you access would reasonably be likely to reveal the source of the information. The decision to deny access under these circumstances is not subject to review. In addition, access may be denied if (i) access to the information is reasonably likely to endanger the life and physical safety of you or anyone else, (ii) the information makes reference to another person and your access would reasonably be likely to cause harm to that person, or (iii) you are the personal representative of another individual and a licensed health care professional determines that your access to the information would cause substantial harm to the client or another individual. If access is denied for these reasons, you have the right to have the decision reviewed by a health care professional who did not participate in the original decision. If access is ultimately denied, the reasons for that denial will be provided to you in writing.

Request an amendment of PHI. If you feel that your PHI maintained by this office is incomplete or incorrect, you may request that the information be amended. You may request an amendment for as long as this office maintains the PHI. To request an amendment, please send a written request to this office. In certain situations, this office may deny your request for amendment. If your request to have your PHI amended is denied, you may submit a written statement of disagreement with the decision to PEGGY HILL AND WINDWARD BIOFEEDBACK ASSOCIATES. Your statement will be kept on file and distributed with all future disclosures of the information to which it relates.

Receive an accounting of disclosures of PHI. You have the right to an accounting of any disclosures of your health information made during the six-year period preceding the date of your request for purposes other than treatment, payment, or health care operations. The accounting will exclude disclosures this office has made directly to you or to persons involved in your care, incidental disclosures permitted by law, disclosures for notification purposes, disclosures that occurred prior to April 14, 2003, and disclosures made pursuant to an authorizations signed by you. The right to receive and accounting is subject to certain other exceptions, restriction, and limitations. To request an accounting, please submit your request in writing to PEGGY HILL AND WINDWARD BIOFEEDBACK ASSOCIATES.

PEGGY HILL AND WINDWARD BIOFEEDBACK ASSOCIATES is permitted and sometimes required by law to use and disclose your PHI without obtaining your prior authorization. The following examples describe different ways that this office may use and disclose PHI about you.

Treatment. This office may use or disclose your PHI for the purpose of providing, or allowing others to provide, treatment to you. An example would be if this office discloses your health information to a doctor for the purposes of a consultation. Also, we may contact you with appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Payment. This office may use and/or disclose your health information for the purpose of allowing us to secure payment for the health care services provided to you. For example, we may inform an insurer or third party payer of your diagnosis and treatment in order to assist the payer in processing our claim for the health care services provided to you.

Health Care Operations. This office may use and/or disclose your information for the purposes of our day-to-day operations and functions. We may also disclose your information to another other healthcare providers to allow them to perform their day-to-day functions, but only to the extent that we both have a relationship with you. For example, we may compile your health information, along with that of other consumers, in order to allow our health care professionals to review that information and make suggestions concerning how to improve the quality of healthcare provided by us.

As required by law. This office must disclose PHI about you when required to do so by law.

For public health purposes. As required by law, this office may disclose PHI about you to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Victims of abuse, neglect, or domestic violence. This office may disclose PHI about you if this office reasonably believes you are a victim of abuse, neglect, or domestic violence.

Health oversight activities. This office may disclose PHI about you to an oversight agency to conduct audits or civil, administrative or criminal investigations as authorized by law. Some of these oversight activities are necessary for our licensure, accreditation, and compliance with contracts.

Judicial and administrative proceedings. If you are involved in a lawsuit or a dispute, this office may disclose PHI about you in responses to a court or administrative order, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the requested PHI.

Law enforcement purposes. This office may disclose PHI about you in response to law enforcement requests, such as subpoena.

Coroners, medical examiners, and funeral directors. This office may release information about you to assist coroners, medical examiner, or funeral directors with their official duties.

Organ, eye, or tissue donation. This office may disclose your PHI to organ or tissue procurement entities as applicable by law.

Research purposes and projects that THIS OFFICE undertakes. This office may disclose PHI about you to researchers when the research has been evaluated and approved through a research approval process that takes into account the consumer right for privacy.

To avert a serious threat to health and safety. This office may disclose PHI about your to avert a serious threat to your health and safety or to health and safety of the public or another person.

Governmental functions. This office may disclose PHI about you for specialized governmental functions such as military, national security, criminal corrections, or public benefit purposes.

Worker's compensation. This office may disclose PHI about you to comply with laws relating to worker's compensation or other programs established by law.

Other Uses and Disclosures of PHI: This office may disclose to your relatives or close personal friends any health information that is directly related to that relative's/friend's involvement in the provision of, or payment for, your care. However, except in emergency situations, you will be informed of our intended action prior to making such disclosures and will, at that time, offer you the opportunity to object. In all other situations, this office will obtain your written permission before using or disclosing PHI about you for purposes other than those stated above. You may revoke your written permission at any time. Upon receipt and approval of your revocation request, this office will stop using or disclosing PHI about you except to the extent that this office has already done so prior to your revocation.

What to do if your feel your privacy rights have been violated: If you feel your privacy rights have been violated, this office wants to hear from you. You may file a complaint directly with PEGGY HILL AND WINDWARD BIOFEEDBACK ASSOCIATES at 319B Kihapai Street, Kailua, Hi, 96734. This office assures you there will be no retaliation against you for filing a complaint.

I certify that I am aware of my rights and have been offered a copy of them.

_____ _____

Signature Date

_____

Printed Name

Please Read and Sign this Important Information
ABOUT YOUR MEDICAL INSURANCE COVERAGE

We will be unable to bill your insurance unless we have a copy of your current insurance card or a completed insurance form for each insurance carrier. We will make every effort on your behalf to collect payment from your insurance company first. You are responsible for any co-payment, taxes and non-covered services. To keep your costs as low as possible, we ask that you assist us with our billing procedures.

MEDICARE PATIENTS: Peggy Hill, LCSW is a Medicare participating provider. This means that we will bill Medicare the Medicare allowed fee with the remaining 20% paid by you or your Medicare supplement insurance. Medicare patients are also responsible for the annual Medicare deductible and all non-covered services including Brain Mapping and some specific Neurofeedback procedures. You will be informed in advance when a service is not covered.

PARTICIPATING INSURANCE PLANS: As per Medicare, all charges will be billed, but some services are not covered including annual deductible and all non-covered services including Brain Mapping and some specific Neurofeedback procedures. You will be informed in advance when the therapist knows a service is not covered. However you are also responsible for knowing your plan's deductible and copayment expectation, and for making the therapist aware of your financial obligation.

NON-PARTICIPATING INSURANCE: If you have insurance with a private carrier we will make every effort to bill your insurance company, however **you** are responsible for all charges incurred. These are payable at the time of your visit. Your private insurance company will reimburse you directly. A request to complete insurance forms on your behalf must be accompanied by a completed insurance form at each visit, unless your insurance carrier accepts the standard HCFA 1500 form. At this time non-participating insurance companies include but are not limited to HMA, Wellcare-Ohana and out of state Blue Cross-Blue Shield plans.

INSURANCE PAYS CLIENT DIRECTLY: If your insurance pays you directly, although the bill was submitted by the therapist on an assignment basis, you, the client, are responsible to release the check to the therapist.

NON-COVERED SERVICES AND TAXES: There are some services, as well as taxes, that your medical insurance may not cover at all and payment for these services and taxes are your responsibility. Payment for these non-covered services and taxes are billed through our billing service SMA Billing Solutions. Failure in prompt payment of bills will result in termination of services.

CO-PAYMENTS: Most medical insurance coverage plans contain client copayment provisions. It is your responsibility to pay this expense. Our billing service, SMA Billing Solutions, will bill you directly for copayment and tax on the full amount of the covered expense. This bill will arrive after payment for services has been obtained from the insurance company.

PRIVATE PAYMENT: Private payment is available and is paid directly at the end of each visit or upon booking the service through the automatic scheduling service. Ms. Hill's session rate is $125 per visit. Payment may be made by cash or check. Sessions may also be purchased in 10 session packages at $1150 per package

BRAIN MAPPING is not covered by insurance and is charged at $35 per mapping session, payable at the time of the session. Brain mapping is an optional service but is strongly recommended.

_____ _____

Signature of Patient or Representative Date

CONSENT FOR PSYCHOTHERAPY, BIOFEEDBACK AND/OR NEUROFEEDBACK TREATMENT

Re: _____

Peggy Hill and Staff at Windward Biofeedback Associates offer psychotherapy, biofeedback and/or EEG (brain wave) Neurofeedback (NFB) training to clients in connection with a variety of conditions, some of which appear to be associated with irregular brain activity and some of which appear to be associated with problems with self-regulation: these conditions include hyperactivity and attention deficit disorder, specific learning disabilities and conduct problems, as well as certain sleep disorders, depression, anxiety, chronic pain, minor head injury, seizure disorders, and other conditions.

Peggy Hill and Staff at Windward Biofeedback Associates are not physicians. They are aware, by training, experience, and through the literature, of beneficial effects of the kind of psychotherapy, Biofeedback, and Neurofeedback (NFB) they offer. Scientific investigation is ongoing to determine the mechanism by which these benefits are achieved. At present, Peggy Hill and Staff at Windward Biofeedback Associates recommend biofeedback/neurofeedback training based on research and empirical observation of improvement in clients with similar conditions. We strongly suggest the use of a brain map to improve outcomes.

No representation is made that any individual client will improve from treatment. There is some indication that in a few clients who do experience benefit using biofeedback/NFB techniques, the improvement may fall off after the cessation of training. These individuals would benefit from periodic follow-up, or booster sessions. The training appears to be a harmless procedure as far as is known at present. No injuries are known in the experience of staff of this clinic, or in the literature reviewed. Nevertheless, beyond this, no representation is made concerning the safety or efficacy of the training. Any questions should be addressed to the prospective client's physician. The client should continue ongoing therapies until otherwise advised by his physician.

It is the client's own responsibility to monitor the subjective effects of treatment/training, and to continue psychotherapy and/or training so long as benefit is perceived. Windward Biofeedback Associates provides assessment tools and encourages the client to evaluate progress after each ten sessions to determine if further training is indicated. Windward Biofeedback Associates invites discussion at this point, or at any point in the therapy or training.

By signing this form, the client indicates his/her understanding of the principles set forth here, and waives any claim of damages due to the treatment/training, including worsening of the client's condition for which treatment/training t was undertaken, claimed side effects, or the failure to improve with treatment/training. In addition, the client agrees to take full responsibility for his/her treatment/training, the benefit of such treatment/training, or the lack thereof, and further agrees to hold Windward Biofeedback Associates harmless from all claims associated with such treatment/training.

The client further agrees that Peggy Hill and staff of Windward Biofeedback Associates may consult with the client's primary care practitioner or specialist with regard to the NFB training, and the results obtained. The client further agrees **☐Yes ☐No** that the data obtained in connection with the NFB training may be used by Windward Biofeedback Associates in publications, with protection of the privacy and preservation of the anonymity of the client. The client agrees to submit any dispute with Peggy Hill/Windward Biofeedback Associates to binding arbitration under the rules of the American Arbitration Association. If the client is a minor, the parent or guardian of the aforesaid client agrees to these conditions on behalf of the client.

CONSENT FOR TREATMENT

I have received a copy of the HIPAA Federal guidelines concerning client confidentiality and portability of health insurance, and my questions about this guideline have been answered.

I acknowledge that I have received information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received.

I know that I must **cancel an appointment at least 24 hours** before the time of the appointment... If I do not cancel and do not attend, there is a late cancellation fee, as I reserved that time exclusively and insurance companies do not cover the cost of missed appointments. **For the first late cancellation, the fee is $25 to be paid prior to the next visit.** Subsequent missed appointments may be billed at a higher rate up to and including the insurance company allowed fee + copay.

I am aware that sessions are scheduled for 50 minutes duration. If I am late, it's possible I may receive a partial session.

_____ _____

Signature of Patient or Representative Date

.

Client:_____Parent/Guardian _____

Age:__ Date of Birth:_____M/F If child: Grade:____ School:_____Teacher: _____

Physician/Primary Care Specialist:_____Tel _____

Psychiatrist:_____Tel: _____

Current Medications: _____

Other Care Provider:_____Tel _____

Personal goals for treatment: (1)_____

(2)_____

(3)_____

Comments:_____

_____

Diagnosis:_____

PLEASE COMPLETE ALL INFORMATION IN NEXT SECTION

Payment Information & Life Time Insurance Authorization

Provider's Name: **Margaret S. Hill (Peggy), LCSW, Board Certified in Neurofeedback (BCN)**

Provider's Address:____319 B Kihapai Street, Kailua, Hi, 96734

Client's Name:_____ DOB:_____

Client's Address: _____City:_____Zip:_____

e-mail:_____Cell phone:_____Home Phone:_____

Medical Insurance Plan:_____Plan Number:_____

Billing Authorization Period: From:_____To:*_____(* or until revoked/rescinded)

Please initial appropriate boxes:

_____I request that payment under the medical insurance program be made either to me or to the provider named above on any bills for services furnished to me during the effective period of this authorization, and I authorize the above-named provider to release to the Managed Care Medical Insurance Plan and/or Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medical Insurance. Medicaid, and/or Medicare claim. I further permit a copy of this authorization to be used in place of the original.

_____I understand that I am personally responsible for all mandated co-payments and for State of Hawaii GE tax on full amount your insurance company allows for the session. I understand that I will receive a monthly statement of these charges with information about insurance company payments. I understand that Managed Care Medical Insurance Plans may reject the claim or limit visits to a predetermined number. I understand that on occasion Medical Insurance may reimburse the patient for services rendered, and I'm responsible for sending these payments to the therapist unless I have prepaid for services rendered. I understand that some services may not be covered by insurance.

_____ I **agree to cover the cost of any treatment visits not covered or disallowed by my medical plan at the same cost paid by the medical plan.**

_____**I understand that I am responsible to attend** a scheduled appointment or to notify WBA of cancellation at least 24 hours in advance. If I fail to cancel in advance of a scheduled appointment I will be responsible for a late **cancellation fee is $25 to be paid prior to the next visit** as I have reserved that time exclusively. Subsequent late cancellations may be billed at the full session rate, stated below. I understand exceptions are made to this rule for illness, accident and unforeseeable traffic conditions

. . . . . OR. . . . . .

_____I will pay privately. Private rate is: **$ 125** per session to be paid at end of each session by cash or check. Sessions may be purchased in packages of 10 for $1150.

Date:_____Client's/Guardian's Signature:_____

Peggy Hill, LCSW, BCN Board Certified in Neurofeedback
Windward Biofeedback Associates
319B Kihapai Street
Kailua, Hi 96734
Tel. (808) 781-3007

Request/Authorization to Obtain Confidential Records and Information

I hereby authorize my primary care physician OR the person named:_____

Address: _____Phone: _____

to release information from records about _____born on:_____

for the purpose of coordinating care

These records concern the time between _____ and _____

The information to be disclosed is marked by an X in the boxes below, and the items not to be released have a line drawn through them. Page numbers are indicated when appropriate.

❑Intake and discharge summaries ❑ Medical history and evaluation(s) ❑Mental health evaluations

❑Developmental and/or social history ❑ Educational records

❑Progress notes, and treatment or closing summary ❑Other: _____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here**:** **❑Do not release.**

Please forward the records to the address in the letterhead at the top of this form.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

Signature of client	Printed name		Date
Signature of parent/ guardian/representative	Printed name	Relationship	Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

Signature of witness	Printed name	Date

□Copy for patient or parent/guardian □Copy for source of records □Copy for recipient of records

Peggy Hill, LCSW, BCN Board Certified in Neurofeedback
Windward Biofeedback Associates
319B Kihapai Street
Kailua, Hi 96734
Tel. (808) 781-3007

Request/Authorization to Release Confidential Records and Information

I hereby authorize Peggy Hill and Windward Biofeedback Associates at the above address to release information from records about _____ born on: _____ to my Primary Care Physician or the person named: _____ (address) _____ (phone/fax) _____ for the purpose of coordinating care.

These records concern the time between _____ and _____

The information to be disclosed is marked by an X in the boxes below, and the items not to be released have a line drawn through them. Page numbers are indicated when appropriate.

❑Intake and discharge summaries ❑Medical history and evaluation(s) ❑Mental health evaluations
❑Developmental and/or social history ❑Educational records ❑Progress notes, and treatment or closing summary
❑Other: _____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here**:** ☐**Do not release.**

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____

Signature of client Printed name Date

_____

Signature of parent/ guardian/representative Printed name Relationship Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____

Signature of witness Printed name Date ☐Copy for patient or parent/guardian ☐Copy for source of records ☐Copy for recipient of records

DASS 21

Name _____ **Date** _____

Please read each statement and circle a number 0, 1, 2, or 3 that indicates how much the statement applied to you over the past week. There is no right or wrong answer. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all

1 Applied to me to some degree, or some of the time

2 Applied to me to a considerable degree, or a good part of time

3 Applied to me very much, or most of the times

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (e.g., in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Symptom Inventory: name: date: (score)

Please read each statement and circle a number 0, 1, 2, or 3 that indicates how much the statement applied to you over the PAST MONTH. There is no right or wrong answer. Do not spend too much time on any statement. The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree
3 Applied to me very much, or most of the times

Sleep

0	1	2	3	Difficulty falling asleep
0	1	2	3	Difficulty maintaining sleep
0	1	2	3	Difficulty waking
0	1	2	3	Nightmares or vivid dreams
0	1	2	3	Night terrors
0	1	2	3	Restless sleep
0	1	2	3	Snoring
0	1	2	3	Sleep apnea
0	1	2	3	Tooth grinding (Bruxism)
0	1	2	3	Sleep walking
0	1	2	3	Talking during sleep
0	1	2	3	Night sweats
0	1	2	3	Can't stay awake during the (
0	1	2	3	Periodic leg movements

Attention and learning

0	1	2	3	Inattention
0	1	2	3	Poor short-term memory
0	1	2	3	Distractibility (trouble sitting still)
0	1	2	3	Doesn't try very hard
0	1	2	3	Trouble finishing things
0	1	2	3	Difficulty thinking clearly
0	1	2	3	Difficulty making decisions
0	1	2	3	Poor vocabulary
0	1	2	3	Messy handwriting
0	1	2	3	Poor drawing ability
0	1	2	3	Poor math
0	1	2	3	Reading difficulty
0	1	2	3	Not listening
0	1	2	3	Lacking common sense

Sensory

0	1	2	3	Visual hypersensitivity
0	1	2	3	Auditory hypersensitivity
0	1	2	3	Tactile hypersensitivity
0	1	2	3	Tinnitus
0	1	2	3	Vertigo
0	1	2	3	Visual deficits
0	1	2	3	Chemical sensitivities
0	1	2	3	Somato-sensory deficits
0	1	2	3	Poor body awareness
0	1	2	3	Motion sickness
0	1	2	3	Clumsiness
0	1	2	3	Poor grooming

Behavioral

0	1	2	3	Stuttering
0	1	2	3	Poor Speech articulation
0	1	2	3	Impulsivity
0	1	2	3	Rages
0	1	2	3	Hyperactivity
0	1	2	3	Class clown
0	1	2	3	Motor or vocal tics
0	1	2	3	Compulsive behaviors
0	1	2	3	Inflexibility
0	1	2	3	Manipulative behavior
0	1	2	3	Aggressive behavior
0	1	2	3	Oppositional/defiant
0	1	2	3	Crying
0	1	2	3	Poor eye contact
0	1	2	3	Autistic stimming
0	1	2	3	Addictive behaviors
0	1	2	3	Nail biting
0	1	2	3	Lack of social interest
0	1	2	3	Lack of appetite awareness
0	1	2	3	Compulsive eating
0	1	2	3	Binging and purging
0	1	2	3	Lack of sense of humor

Emotional

0	1	2	3	Irritability
0	1	2	3	Agitation
0	1	2	3	Emotional reactivity
0	1	2	3	Mood swings
0	1	2	3	Depression
0	1	2	3	Mania
0	1	2	3	Anxiety
0	1	2	3	Fears
0	1	2	3	Obsessive worries
0	1	2	3	Lack of emotional awareness
0	1	2	3	Lack of social awareness
0	1	2	3	Low self-esteem
0	1	2	3	Panic attacks
0	1	2	3	Flashbacks of trauma
0	1	2	3	Dissociative episodes
0	1	2	3	Anger
0	1	2	3	Impatience
0	1	2	3	Suicidal thoughts
0	1	2	3	Paranoia

Physical

0	1	2	3	Low muscle tone
0	1	2	3	Spasticity
0	1	2	3	Chronic constipation
0	1	2	3	Irritable bowel
0	1	2	3	Seizures
0	1	2	3	Poor fine motor coordination
0	1	2	3	Poor gross motor coordinatic
0	1	2	3	Poor balance
0	1	2	3	Immune deficiency
0	1	2	3	PMS symptoms
0	1	2	3	Heart palpitations
0	1	2	3	Tachycardia
0	1	2	3	High blood pressure
0	1	2	3	Reflux
0	1	2	3	Tremor
0	1	2	3	Rigidity
0	1	2	3	Fatigue
0	1	2	3	Asthma
0	1	2	3	Sugar craving and reactivity
0	1	2	3	Allergies
0	1	2	3	Hot flashes
0	1	2	3	Muscle tension
0	1	2	3	bedwetting/daytime accidents

Pain

0	1	2	3	Chronic aching pain
0	1	2	3	Migraine headaches
0	1	2	3	Muscle tension headaches
0	1	2	3	Trigeminal neuralgia
0	1	2	3	Sciatica
0	1	2	3	Fibromyalgia pain
0	1	2	3	Chronic nerve pain
0	1	2	3	Stomach aches
0	1	2	3	Intestinal pain
0	1	2	3	Joint pain
0	1	2	3	Neuropathy pain
0	1	2	3	Muscle pain
0	1	2	3	Jaw pain

Medications: