

Psychoeducational Clinic

Welcome Packet

Welcome to the Psychoeducational Clinic!



We look forward to working with you and your child and hope that you will find your visit with us rewarding. We have prepared this information packet to help you prepare for your visit. If you have additional questions, feel free to call us at 919-515-1713.

Included in this information packet, you will find:

- Background on the Psychoeducational Clinic (pg.2)
- Information about appointments (pg.3)
- Scheduling “to-do” checklist (pg.3-4)
- Contact information (pg.5)
- Background questionnaire (pg.6)

About the Psychoeducational Clinic

The Psychoeducational Clinic is affiliated with the School Psychology program, which is housed within the Department of Psychology at NCSU. The Clinic is a practicum and internship site for master's and doctoral level school psychology graduate students. The field of school psychology applies psychological and learning principles to increase the effectiveness of school systems, schools, teachers, and students. The Clinic has been in existence for over fifty years and serves children, adolescents, and young adults. Our Clinic services include educational and behavioral consultation, psychological/psychoeducational evaluations, and the assessment of social, emotional, behavioral, and learning needs. The Psychoeducational Clinic also provides intervention services to children, adolescents and young adults designed to address social/emotional difficulties (e.g., anxiety, emotional dysregulation, and impulsivity), as well as programs to help students improve organizational and study skills.

Clinic staff includes three Ph.D. School Psychologists and one master's level Clinical Psychologist. **Dr. Natalie Murr** is the Clinic Director. She is also a Licensed Psychologist and holds a doctoral degree in School Psychology from North Carolina State University and a master's degree in Comparative Social Policy from Oxford University. Interests include learning differences, developmental and intellectual disabilities, educational policy and advocacy, and improving educational and learning outcomes for all students. **Ms. Sasha Fradin**, Licensed Psychological Associate, holds a master's degree in clinical psychology from East Carolina University and has worked at the Duke University Center for Child and Family Policy and at All Kinds of Minds in Chapel Hill. Interests include learning differences, memory in children and adolescents, and emotional and behavioral difficulties. **Dr. Whitney Griffin** is also a Licensed Psychologist with the Clinic. She earned a doctoral degree in School Psychology from North Carolina State University and also holds a master's degree in Special Education from East Carolina University. Interests include autism spectrum disorder, intellectual and developmental disabilities, and the social emotional development of children, adolescents, and young adults. Whitney is also an Education Specialist at the Carolina Institute for Developmental Disabilities. Prior to becoming a psychologist, she worked as a special education teacher and autism specialist in the public schools for over a decade. Finally, **Dr. Kate Norwalk** holds a doctoral degree in School Psychology from Penn State University. She currently works at NC State as an Assistant Professor, with special interests in supporting youth through the middle school transition, children and adolescents' social development, peer relationships, foster care and other out-of-home placements, and the effects of trauma on children's development. Two doctoral students in the School Psychology program- **Ms. Jerica Knox** and **Ms. Jessica Hernandez**- work as assistants in the clinic and are responsible for scheduling and responding to general questions. You may have spoken with one of them already by phone.

Either one of the clinicians listed above or a team consisting of psychologists and graduate students will work with your family. Whether a team or a single psychologist serves your family, the goal of the evaluation is always to answer your referral concerns and develop intervention strategies with as much clarity and expertise as possible, based on the latest research. The Clinic is committed to excellence in care for the child as well as the school and home systems upon which the child relies.

Appointments

The first appointment is typically an *intake meeting* with you, your child, and your child's ACES coach. This meeting is a time for you to share with us your reasons for choosing ACES for your child, as well as a time for us to better understand relevant issues and answer any questions you might have. In addition, we will use this time to discuss your goals and determine the ideal length of service needed to meet those goals. You should set aside an hour for the intake session. At this time, all intake appointments are being held remotely (via Zoom) to abide by social distancing measures and help reduce the spread of coronavirus throughout the community.

After the initial intake meeting, each subsequent ACES session is held once per week and lasts approximately 45 minutes. We are providing both in-person and remote sessions at this time.

Scheduling an Evaluation: What You Need To Do

1. Print and complete the *Background Questionnaire* (starts on pg.6)
2. Print the *Clinic Policies and Service Agreements* packet that was included as a separate email attachment to your welcome email.
3. Read our *General Policies* document.
4. Read and sign the *Consent for Services* document indicating that you have read our policies and that you consent for services for your minor child.
5. Read and sign the *Consent for In-Person Testing* and *Consent for Telehealth* forms which outline all COVID-19 related policies and practices.
6. Collect and copy reports of any previous individual evaluations completed on your child (psychological, speech/language, occupational therapy, etc.)
7. If your concern revolves around a specific academic area, send (or bring with you later) any work samples, report cards, or progress monitoring data that you think would be useful for us to see.
8. Locate a small picture of your child (preferably no bigger than 3 x 5)
9. Prepare your deposit by either: 1) making out a check for \$150 payable to NCSU (refundable in the event of timely cancellation) with your child's full name written at the bottom, OR 2) submitting a credit card deposit through our online system (go.ncsu.edu/paymyclinicbill). More information about our credit card policies can be found on page 3 of our *Clinic Policies and Service Agreement* document. Please note that there are additional fees associated with this option.

(continued on next page)

10. Return:

- a. Background questionnaire
- b. All three consent forms
- c. Copies of previous testing (if any)
- d. Copy of IEP or 504 plan and other documentation
- e. Deposit check (unless a credit card deposit was made)
- f. Picture

**To: The Psychoeducational Clinic, Scheduling Officer
Department of Psychology, Box 7650
NCSU
Raleigh, NC 27695-7650**

Once your information is received in the Clinic, personnel will call or email to schedule your child's appointments.

Contact Information

If you have any questions or concerns, please do not hesitate to contact us using one of the methods listed below. Please note that many of our faculty and staff are working from home. Still, voicemail and email is monitored frequently, so please feel free to leave us a message and we will respond to your inquiry within 24-48 hours.

Mailing Address: Psychoeducational Clinic
Department of Psychology, Box 7650
North Carolina State University
Raleigh, NC 27695-7650

Street Address: 2310 Stinson Drive, Poe Hall, Suite 612

Telephone: 919-515-1713

Fax: 919-515-1716

Web Site: <http://go.ncsu.edu/psychedclinic>

BACKGROUND QUESTIONNAIRE

Date: _____ Person Completing Form _____

Student Information

Name: _____ Preferred Name: _____

Address: _____ Gender: _____

County: _____ Home Phone: _____

Date of Birth: _____ Age: _____

School: _____ Grade: _____

Family Information

Parent/Caregiver

Name: _____ Occupation: _____

Address _____ Employer: _____

(if different): _____

Work Phone: _____ Email: _____

Cell Phone: _____ Education: _____

Parent/Caregiver

Name: _____ Occupation: _____

Address _____ Employer: _____

(if different): _____

Work Phone: _____ Email: _____

Cell Phone: _____ Education: _____

Parent Marital Status: ____ Married ____ Separated ____ Divorced ____ Widowed ____ Never Married

If divorced, describe custody arrangements: _____

Is there another caregiver in the home? ____ Yes ____ No

Name and relationship to student: _____

Are all legal guardians aware of this service? ____ Yes ____ No

Siblings

<u>Name</u>	<u>Age</u>	<u>Sex</u>	<u>Living at home?</u>
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Referral Question

Who referred you to the clinic? _____

What motivates you to register your child for our ACES program at this time?

When were problems first noticed? When did they become a significant concern?

**What interventions have been attempted at home and at school to help solve the problem(s)?
How helpful have they been?**

Has your child ever participated in therapy or consulted with a mental health professional before?
Yes _____ No _____

If yes, when and by whom?

Does your child have a medical or psychological/mental health diagnosis that may be affecting his/her schoolwork?

Specific Areas of Concern

Please provide further information about your concerns. In the spaces below, please list the most troubling problems exhibited by your child for which you are seeking help. Be as specific as you can. For each area of difficulty, please indicate the number which best describes the amount of concern or distress you and your child feel about that problem.

Problem 1:

In general, how much does this problem bother your child?

Not at all

☐ 1

☐ 2

☐ 3

☐ 4

☐ 5

☐ 6

☐ 7

Couldn't be worse

In general, how problematic do you think this problem is for your child?

Not at all

☐ 1

☐ 2

☐ 3

☐ 4

☐ 5

☐ 6

☐ 7

Couldn't be worse

Problem 2:

In general, how much does this problem bother your child?

Not at all

☐ 1

☐ 2

☐ 3

☐ 4

☐ 5

☐ 6

☐ 7

Couldn't be worse

In general, how problematic do you think this problem is for your child?

Not at all

☐ 1

☐ 2

☐ 3

☐ 4

☐ 5

☐ 6

☐ 7

Couldn't be worse

Problem 3:

In general, how much does this problem bother your child?

Not at all

☐ 1

☐ 2

☐ 3

☐ 4

☐ 5

☐ 6

☐ 7

Couldn't be worse

In general, how problematic do you think this problem is for your child?

Not at all

☐ 1

☐ 2

☐ 3

☐ 4

☐ 5

☐ 6

☐ 7

Couldn't be worse

Medical and Mental Health Information

Place a check next to any illness or condition that your child has had.

When you check an item, also note the approximate date (or age) of illness.

<i>Check</i>	<i>Illness</i>	<i>Date/age</i>	<i>Check</i>	<i>Illness</i>	<i>Date/age</i>
_____	Allergy	_____	_____	Extreme tiredness	_____
_____	Asthma	_____	_____	or weakness	_____
_____	Head injury	_____	_____	Anemia	_____
_____	Broken bones	_____	_____	Fainting Spells	_____
_____	Hearing Problems	_____	_____	Severe Headaches	_____
_____	Ear Infections	_____	_____	Stomachaches	_____
_____	Vision Problems	_____	_____	Eating Disorders	_____
_____	Convulsions	_____	_____	Dizziness	_____
_____	Diabetes	_____	_____	Epilepsy	_____
_____	Encephalitis	_____	_____	Eczema/hives	_____
_____	High Fever	_____			
_____	Hospitalizations	_____ (explain) _____			
_____	Other	_____ (explain) _____			

Explanations for any other of the above:

Check any of the following behaviors your child/adolescent exhibits. If your child exhibits none of these behaviors, skip this section. For items checked, please explain in the space provided the extent of the behavior and under what conditions it occurs.

PHYSICAL	<u>Sometimes</u>	<u>Often</u>	<u>Explanations</u>
complains of headaches	_____	_____	_____
complains of stomachaches	_____	_____	_____
thumbsucking	_____	_____	_____
nailbiting	_____	_____	_____
other	_____	_____	_____
BEHAVIORAL			
under/overeating	_____	_____	_____
stealing	_____	_____	_____
stuttering	_____	_____	_____
crying	_____	_____	_____
daydreaming	_____	_____	_____
temper tantrums/meltdowns	_____	_____	_____
bossing others	_____	_____	_____
bedwetting	_____	_____	_____
aggressiveness	_____	_____	_____
lying	_____	_____	_____
disobedient/defiant	_____	_____	_____
runs away	_____	_____	_____
engages in self-injurious behavior	_____	_____	_____
disruptive	_____	_____	_____
inattention/distractibility	_____	_____	_____

touches others inappropriately	_____	_____	_____
difficulty sleeping	_____	_____	_____
destructive	_____	_____	_____
unusually active	_____	_____	_____
diff. getting along with peers	_____	_____	_____
diff. getting along with adults	_____	_____	_____
alcohol/substance use	_____	_____	_____
acts without thinking	_____	_____	_____
diff. finishing work on time	_____	_____	_____
forgetful	_____	_____	_____
interrupts or trouble waiting turn	_____	_____	_____
loses things	_____	_____	_____
other	_____	_____	_____

EMOTIONALSometimesOftenExplanations

nervous/anxious	_____	_____	_____
depressed/sad	_____	_____	_____
withdrawn	_____	_____	_____
moody	_____	_____	_____
complains of unfairness	_____	_____	_____
says no one understands him/her	_____	_____	_____
has nightmares	_____	_____	_____
poor self-image	_____	_____	_____
suicidal	_____	_____	_____
other	_____	_____	_____

Medications taken or taking other than for routine illnesses:MedicationReasonDoseDate StartedDate Stopped

Family Medical History

Place a check next to any illness or condition that any member of the family has had.

When you check an item, please note the member's relationship to the child.

<i>Check</i>	<i>Condition</i>	<i>Relationship</i>
_____	Alcoholism	_____
_____	Anxiety Disorder	_____
_____	Obsessive-Compulsive Disorder	_____
_____	Depression	_____
_____	Suicide attempt	_____
_____	Bipolar Disorder	_____
_____	Autism	_____
_____	Asperger's Disorder	_____
_____	Intellectual disabilities	_____
_____	Attention difficulties:	Suspected _____
		Confirmed _____
_____	Reading Disability:	Suspected _____
		Confirmed _____
_____	Math Disability:	Suspected _____
		Confirmed _____
_____	Other _____	_____

Please note any issues which you as a parent might have coped with as a child, or currently be coping with as an adult, which might also affect your child.

Educational History

List schools your child has attended, grades, and dates (including preschools):

<u>School</u>	<u>Grade</u>	<u>Dates</u>
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Is your child in (or been in) a special education or academically gifted class? Yes ____ No ____

If yes, what type of class? _____ When? _____

Has your child been held back in a grade? Yes ____ No ____

If yes, what grade and why? _____

Has your child ever received tutoring or therapy in or outside of the school setting? Yes ____ No ____

If yes, please describe: _____

Rate your child's performance in the following areas by placing a check in the appropriate column:

Subject	Clear Problem Area	Sometimes a Problem	About Average	Somewhat of A Strength	Clear Area of Strength
Reading decoding					
Reading comprehension					
Math mechanics					
Math conceptual skills					
Written expression					
Spelling					
Handwriting					
Science					
Social Studies					
Foreign Languages					
Test Taking					
Organizational skills					
Social Skills					

Strongest subject(s): _____

Weakest subject(s): _____

What grades is your child making? _____

What accommodations does your child receive, if any?

Other Background Information

Has your child ever had a psychological or psychoeducational evaluation? Yes _____ No _____

If yes, when and by whom? _____

Did the evaluation result in a diagnosis? If so, what was it? _____

Place a check next to any of the diagnoses that apply:

- | | |
|---|---|
| <input type="checkbox"/> Reading Disability | <input type="checkbox"/> Attention Disorder (inattentive) |
| <input type="checkbox"/> Writing Disability | <input type="checkbox"/> Attention Disorder (hyperactivity/impulsivity) |
| <input type="checkbox"/> Math Disability | <input type="checkbox"/> Attention Disorder (combined) |
| <input type="checkbox"/> Language Disorder | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Other: _____ |

What does your child like to do?

What are your child's strengths?

Is there any other information that you think may help us in working with your child?

Please return the following with this form:

- Copies of reports previously conducted by psychologists, speech/language professionals, audiologists, etc. Also include any individual testing conducted by school personnel.
- Copies of recent report cards;
- Consent for Services (signed)
- A recent picture of your child
- Deposit- Please indicate the following: ☐ my deposit check of \$100 is included, OR
☐ I have paid my \$100 deposit via credit card