

Please understand that your responses to these forms are confidential and will not be disclosed to anyone without your permission. They are simply meant to better guide me in treatment planning.

Is the client currently, or has he/she in the past, seeing/seen any professional person for his/her challenges? (ex: psychiatrist, psychiatric nurse practitioner, social worker, psychologist, mental health practitioner, school social worker, tutor, etc)? _____ No _____ Yes

Please list every one you can recall below including ALL contact information
Keep in mind that NO other practitioner will be contacted under ANY circumstances without your having signed CONSENT FOR RELEASE OF INFORMATION.

Provider Name: _____ Title: _____
Address: _____
Phone: _____ Fax: _____
From: _____ To: _____ Circle Type of Treatment: individual, group, family, medication, other
Reason for Termination or How is Treatment Working?: _____

Provider Name: _____ Title: _____
Address: _____
Phone: _____ Fax: _____
From: _____ To: _____ Circle Type of Treatment: individual, group, family, medication, other
Reason for Termination or How is Treatment Working?: _____

Provider Name: _____ Title: _____
Address: _____
Phone: _____ Fax: _____
From: _____ To: _____ Circle Type of Treatment: individual, group, family, medication, other
Reason for Termination or How is Treatment Working?: _____

Provider Name: _____ Title: _____
Address: _____
Phone: _____ Fax: _____
From: _____ To: _____ Circle Type of Treatment: individual, group, family, medication, other
Reason for Termination or How is Treatment Working?: _____

If more room is required kindly write on the back of this page

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Has the client had any previous inpatient psychiatric hospitalization for treatment? ___ No ___ Yes
If yes: What facility: _____

What were the precipitating factors that contributed to the admission? _____

Date/s of Admission & Discharge _____

Medication History

Has the client taken ANY prescription medication? _____ No _____ Yes, see below

Medication Name: _____ Dose: _____ How Often: _____
Experienced Side Effects: _____
Prescribing Doctor: _____
Began Taking When? _____ For What? _____
Was/Is it effective at treating the symptoms for which it was prescribed? _____ Yes _____ No
If no please explain: _____

Medication Name: _____ Dose: _____ How Often: _____
Experienced Side Effects: _____
Prescribing Doctor: _____
Began Taking When? _____ For What? _____
Was/Is it effective at treating the symptoms for which it was prescribed? _____ Yes _____ No
If no please explain: _____

Medication Name: _____ Dose: _____ How Often: _____
Experienced Side Effects: _____
Prescribing Doctor: _____
Began Taking When? _____ For What? _____
Was/Is it effective at treating the symptoms for which it was prescribed? _____ Yes _____ No
If no please explain: _____

If more room is required kindly write on the back of this page

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Family Life

Name of Biological Mother: _____

Place of Employment: _____

Name of Biological Father: _____

Place of Employment: _____

Name/s of Step Parent/s: _____

Place/s of Employment: _____

Name of Guardian: _____

Place of Employment: _____

Names of People Living in Household	Age	Relation to Client	Does Client Get Along With Him/Her

Parents: (please check those that apply)

Marital Conflict Parents Divorced Parents Separated Parent/s Deceased

Client's Living Arrangements:

Home w/Other Relative Foster Care Friend's Home Group Home

Custody Concerns:

Who has legal custody/papers? _____

Any upcoming court dates? No If yes, specify _____

Explain visitation arrangements (if any) _____

CPS Involvement? No If yes, please explain _____

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Parenting Dynamics

Who is involved in disciplining? _____

What methods are used? _____

Are they working? Please explain: _____

What is the response of the client? _____

What is your biggest concern, if any, with regard to parenting? _____

Besides occasional family sessions that are a part of the client's treatment, do you feel you would benefit from some parent education/training sessions? If so, what information would be beneficial for you to learn about further? _____

Have you ever attended any sessions or seminars on parenting? _____ No _____ Yes: Please state where, when, and taught by whom: _____

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Recent Concerns

During the Past Year, have there been any of the following concerns in the family? Please check all that apply.

- | | |
|--|--|
| <input type="checkbox"/> Financial problems | <input type="checkbox"/> Mental illness in the family |
| <input type="checkbox"/> Frequent moves | <input type="checkbox"/> Psychiatric hospitalization of a relative |
| <input type="checkbox"/> Job changes | <input type="checkbox"/> Suicide attempt made by a family member |
| <input type="checkbox"/> Drinking/drug problems (not client) | <input type="checkbox"/> Suicide completion of a family member |
| <input type="checkbox"/> Arguments between parents | <input type="checkbox"/> Suicide attempt made by the client |
| <input type="checkbox"/> Arguments between parent/s & client | <input type="checkbox"/> Client engaging in self-injurious behavior |
| <input type="checkbox"/> Arguments between siblings | <input type="checkbox"/> Physical illness of client |
| <input type="checkbox"/> Separation or divorce of parents | <input type="checkbox"/> Physical illness in the family |
| <input type="checkbox"/> Remarriage of parent/s | <input type="checkbox"/> Hospitalization of a family member |
| <input type="checkbox"/> Separation from sibling | <input type="checkbox"/> Death of a relative |
| <input type="checkbox"/> Separation from other family member | <input type="checkbox"/> Death of a friend of the client |
| <input type="checkbox"/> Physical confrontations b/w parents | <input type="checkbox"/> Sexual promiscuity of the client |
| <input type="checkbox"/> Physical confrontations b/w parent/s & client | <input type="checkbox"/> Client abusing drugs |
| <input type="checkbox"/> Physical confrontations b/w siblings | <input type="checkbox"/> Client engaging in bingeing & purging of food |
| <input type="checkbox"/> Incest in the family | <input type="checkbox"/> Arguing over client's peer group |
| <input type="checkbox"/> Frequent punishment of child | <input type="checkbox"/> Other (please explain below) |

If you checked any of the above please explain: _____

How did these problems affect the client? _____

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Family & Client Medical History

Problem

List Relative/s (include client, mother, father, sibling, maternal & paternal grandparent/s, biological aunt/s, uncle/s, cousin/s)

Hypertension	_____
Heart Problems	_____
Heart Attack	_____
HIV Positive/AIDS	_____
Cancer, indicate type if known	_____
Stroke	_____
Diabetes, indicate if taking insulin	_____
Asthma	_____
Genetic Disorder	_____
Glaucoma	_____
Seizure/Epilepsy	_____
Hypo/Hyper Thyroidism	_____
Autoimmune Disease (what type)	_____
Mental Retardation	_____
Behavior Disorder (what type)	_____
Autism Spectrum Disorder	_____
Learning Disorder (what type)	_____
Color Blindness	_____
Depression	_____
Bi-Polar Disorder (I or II)	_____
Borderline Personality Disorder	_____
Anxiety Disorder/Phobias	_____
Post Traumatic Stress Disorder	_____
Schizophrenia	_____
Drug Abuse	_____
Alcoholism	_____
Suicide Attempts	_____
Suicide Completions	_____
Psychotropic Medications	_____
Psychiatric Hospitalization	_____

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Family & Client Medical History Continued

Any other significant medical problems, please explain: _____

Has the client had any major physical illnesses over his/her lifetime? ____ No If yes, please explain

Has the client ever had any of the following: Yes No Age Occurred

Ear Infections	_____	_____	_____
Meningitis or Encephalitis	_____	_____	_____
Head Injury w/loss of Consciousness	_____	_____	_____
Any Significant Injuries	_____	_____	_____
High or Prolonged Fevers	_____	_____	_____
Visual Defects	_____	_____	_____
Sexual Transmitted Infection	_____	_____	_____

Was child ever hospitalized because of any of the above? If yes, list the hospital name, age at admission and duration of stay. _____

Prenatal History

Was your child adopted? _____ Yes _____ No
During pregnancy, was the mother under the care of a doctor? _____ Yes _____ No
Length of Pregnancy? _____ Mths _____ Weeks
Was the mother on medications? _____ Yes _____ No

What medications? _____

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Prenatal History Continued

During pregnancy, did the mother have any of the following? (Check where appropriate)

- | | |
|---|--|
| <input type="checkbox"/> Elevated blood pressure | <input type="checkbox"/> Toxemia |
| <input type="checkbox"/> Accidents or injuries | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Flu or Virus | <input type="checkbox"/> High fevers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Family/Emotional Stress |
| <input type="checkbox"/> Alcohol Use | <input type="checkbox"/> Drug Use |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Autoimmune Disease Activity |
| <input type="checkbox"/> RH/Other Incompatibilities | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Use of Cigarettes | <input type="checkbox"/> Convulsions/Seizures |

Birth History

- | | |
|-----------------------------------|-------------------------------------|
| Length of Labor? _____ | Was labor induced? _____ |
| If induced, was it planned? _____ | Was mother anesthetized? _____ |
| Were forceps utilized? _____ | Was it a breech presentation? _____ |
| Did mother have a cesarean? _____ | Was it a multiple birth? _____ |

Was the delivery unusual in any way? (e.g. was the cord wrapped around the neck, etc.) _____

Birth Weight: _____ lbs. _____ oz.
Apgar Score: _____ At 1 minute: _____ At 5 minutes: _____

In the first few days after birth, did the client have any of the following?

- | | | |
|---|---|---|
| <input type="checkbox"/> Yellow jaundice | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Special nursing care |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Bruises |
| <input type="checkbox"/> Infection | <input type="checkbox"/> Incubator time | <input type="checkbox"/> Oxygen |

If yes to any of the above, please explain: _____

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Birth History Continued

Was the client in a neonatal intensive care unit? _____ Yes _____ No
Did mother and client leave hospital together? _____ Yes _____ No
If not, how long were either of you in the hospital? Why? _____

Did mother suffer from Post Partum Depression? _____ Yes _____ No
For how long? _____
Was mother prescribed any medication? If so, what? _____

Was mother on any medications while pregnant? _____ Yes _____ No
If yes, what & how many mg? _____

Did mother abuse drugs or alcohol while pregnant? _____ Yes _____ No

Infancy/Toddlerhood History

Were there any of the following difficulties for the client?

_____ Suckling _____ Crying _____ Swallowing _____ Sleeping
_____ Holding _____ Colicky _____ Overly responsive or sensitive to sound
_____ Non-responsive

If yes to any of the above, please explain: _____

At what age did the client do the following?

Crawl _____ Walk _____ Talk _____ Toilet Train _____

Were there childhood difficulties with staying dry or with bowel control? _____ No _____ Yes
Please describe: _____

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Childhood Challenges

Please indicate any of the following issues about the client. If possible, please **specify what age** each **began** to occur and **check if** this particular issue is **still of concern** today.

	Age	Yes	Still Today	No
Infant sleep problems	_____	_____	_____	_____
Infant feeding problems	_____	_____	_____	_____
Delayed time in walking	_____	_____	_____	_____
Delayed speech development	_____	_____	_____	_____
Poor speech	_____	_____	_____	_____
Poor coordination	_____	_____	_____	_____
Strabismus (cross eyed)	_____	_____	_____	_____
Difficulty learning to read	_____	_____	_____	_____
Difficulty learning to write	_____	_____	_____	_____
Difficulty deciding lefty or righty	_____	_____	_____	_____
Poor handwriting	_____	_____	_____	_____
Difficulty in math	_____	_____	_____	_____
Overactive	_____	_____	_____	_____
Can't sit still	_____	_____	_____	_____
Acts as if driven by a motor	_____	_____	_____	_____
Excessively verbal	_____	_____	_____	_____
Speaks too loudly	_____	_____	_____	_____
Wears out toys, shoes & clothes	_____	_____	_____	_____
Gets into things	_____	_____	_____	_____
Unpredictable	_____	_____	_____	_____
Can't tolerate delay	_____	_____	_____	_____
Impulsive	_____	_____	_____	_____
Can't accept correction	_____	_____	_____	_____
Temper tantrums	_____	_____	_____	_____
Verbally fights	_____	_____	_____	_____
Physically fights	_____	_____	_____	_____
Destructive to things	_____	_____	_____	_____
Destructive to self	_____	_____	_____	_____
Unresponsive to discipline	_____	_____	_____	_____
Doesn't complete projects	_____	_____	_____	_____
Short attention span	_____	_____	_____	_____
Daydreams	_____	_____	_____	_____
Doesn't follow directions	_____	_____	_____	_____

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Childhood Challenges Continued

Please indicate any of the following issues about the client. If possible, please **specify what age** each **began** to occur and **check if** this particular issue is **still of concern** today.

	Age	Yes	Still Today	No
Lying	_____	_____	_____	_____
Acts unremorseful	_____	_____	_____	_____
Argues with adults	_____	_____	_____	_____
Deliberately annoys others	_____	_____	_____	_____
Blames others for behavior	_____	_____	_____	_____
Angry and resentful	_____	_____	_____	_____
Difficulty controlling worries	_____	_____	_____	_____
Tense or unable to relax	_____	_____	_____	_____
Feeling left out	_____	_____	_____	_____
Unpopular with peers	_____	_____	_____	_____
Frequently tearful	_____	_____	_____	_____
Feels worthless or inferior	_____	_____	_____	_____
Sleeps excessively	_____	_____	_____	_____
Requires 4 hrs. sleep or less	_____	_____	_____	_____
Stealing	_____	_____	_____	_____
Vandalism	_____	_____	_____	_____
Withdrawn	_____	_____	_____	_____
Accident prone	_____	_____	_____	_____
Demands attention	_____	_____	_____	_____
Demands affection	_____	_____	_____	_____
Truancy	_____	_____	_____	_____
Not working up to ability	_____	_____	_____	_____
Overly aggressive	_____	_____	_____	_____
Left back in school	_____	_____	_____	_____
Mirror vision (reading backwards)	_____	_____	_____	_____
Rocking	_____	_____	_____	_____
Easily frustrated	_____	_____	_____	_____
Perseveration: continued or repetitive activity or actions	_____	_____	_____	_____
Limited excessive interest	_____	_____	_____	_____
Responds best to structured rigid atmosphere where decisions are made for him/her	_____	_____	_____	_____

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Diagnostic History

Has the client been diagnosed with a disorder? ___ No ___ Yes: please check any below that apply

Autism Spectrum Disorder:

___ Autistic Disorder ___ Asperger's Disorder ___ PDD-NOS
Age at time of Diagnosis _____ Name of Diagnostician: _____
Address: _____
Phone #: _____ Fax #: _____

Learning Disorder:

___ Reading ___ Written Expression ___ Dyslexia ___ Math ___ Learning Disorder NOS
Age at time of Diagnosis _____ Name of Diagnostician: _____
Address: _____
Phone #: _____ Fax #: _____

Communication Disorder:

___ Expressive Language ___ Mixed Receptive-Expressive Language ___ Phonological
___ Stuttering ___ Communication Disorder NOS
Age at time of Diagnosis _____ Name of Diagnostician: _____
Address: _____
Phone #: _____ Fax #: _____

Developmental Disorder:

___ Mild MR ___ Moderate MR ___ Complex Multiple Developmental Disorder (research dx)
Age at time of Diagnosis _____ Name of Diagnostician: _____
Address: _____
Phone #: _____ Fax #: _____

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Diagnostic History Continued

Attention-Deficit & Disruptive Behavior Disorders:

_____ ADHD inattentive type _____ ADHD hyperactive type _____ ADHD combined type
_____ Oppositional Defiant Disorder _____ Conduct Disorder

Age at time of Diagnosis _____ Name of Diagnostician: _____

Address: _____

Phone #: _____ Fax #: _____

Feeding & Eating Disorders of Infancy or Early Childhood:

_____ Pica _____ Rumination _____ Feeding Disorder of Infancy or Early Childhood

Age at time of Diagnosis _____ Name of Diagnostician: _____

Address: _____

Phone #: _____ Fax #: _____

Tic Disorders:

_____ Tourette's _____ Chronic Motor or Vocal _____ Transient Tic _____ Tic Disorder NOS

Age at time of Diagnosis _____ Name of Diagnostician: _____

Address: _____

Phone #: _____ Fax #: _____

Elimination Disorders:

_____ Encopresis _____ Enuresis (Not Due to a Medical Condition)

Age at time of Diagnosis _____ Name of Diagnostician: _____

Address: _____

Phone #: _____ Fax #: _____

Other Disorders of Infancy, Childhood or Adolescence:

_____ Separation Anxiety _____ Selective Mutism _____ Stereotypic Movement
_____ Reactive Attachment (_____ Inhibited Type _____ Disinhibited Type)

Age at time of Diagnosis _____ Name of Diagnostician: _____

Address: _____

Phone #: _____ Fax #: _____

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Diagnostic History Continued

Mood Disorders:

_____ Major Depressive _____ Dysthymic _____ Depressive Disorder NOS
_____ Bipolar I _____ Bipolar II _____ Cyclothymic _____ Bipolar Disorder NOS
_____ Substance-Induced _____ Mood Disorder NOS

Age at time of Diagnosis _____ Name of Diagnostician: _____

Address: _____

Phone #: _____ Fax #: _____

Anxiety Disorders:

_____ Panic with or w/o Agoraphobia _____ Social Phobia _____ Obsessive-Compulsive
_____ Posttraumatic Stress _____ Acute Stress _____ Generalized Anxiety
_____ Substance-Induced _____ Anxiety Disorder NOS

Age at time of Diagnosis _____ Name of Diagnostician: _____

Address: _____

Phone #: _____ Fax #: _____

Eating Disorders:

_____ Anorexia Nervosa Type: _____ Restricting _____ Binge Eating/Purging
_____ Bulimia Nervosa Type: _____ Purging _____ Nonpurging
_____ Eating Disorder NOS

Age at time of Diagnosis _____ Name of Diagnostician: _____

Address: _____

Phone #: _____ Fax #: _____

Impulse Control Disorders:

_____ Intermittent Explosive _____ Kleptomania _____ Pyromania
_____ Pathological Gambling _____ Trichotillomania _____ Impulse Control Disorder NOS

Age at time of Diagnosis _____ Name of Diagnostician: _____

Address: _____

Phone #: _____ Fax #: _____

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Diagnostic History Continued

Personality Disorders:

_____ Paranoid _____ Schizoid _____ Schizotypal _____ Antisocial
_____ Borderline _____ Histrionic _____ Narcissistic _____ Avoidant
_____ Dependent _____ Obsessive-Compulsive _____ Personality Disorder NOS

Age at time of Diagnosis _____ Name of Diagnostician: _____

Address: _____

Phone #: _____ Fax #: _____

As the client has been growing up, were/are there any of the following concerns in the family?

If yes, please check	Child's age during the time problems occurred
_____ Financial problems	_____
_____ Frequent moves	_____
_____ Job changes	_____
_____ Separation or divorce of parents	_____
_____ Remarriage of parent/s	_____
_____ Separation from sibling	_____
_____ Separation from other family member	_____
_____ Arguments between parents	_____
_____ Physical confrontations b/w parents	_____
_____ Arguments between siblings	_____
_____ Physical confrontations b/w siblings	_____
_____ Drinking/drug problems	_____
_____ Sexual promiscuity	_____
_____ Incest in the family	_____
_____ Frequent punishment of child	_____
_____ Physical illness in the family	_____
_____ Physical hospitalization of family member	_____
_____ Death of a relative	_____
_____ Death of a childhood friend	_____
_____ Mental illness in the family	_____
_____ Psychiatric hospitalization of a relative	_____
_____ Suicide attempt of a family member	_____
_____ Suicide completion of a family member	_____
_____ Other (please state)	_____

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If you checked yes to any family concerns while the client has been growing up on the former page, please explain in detail: _____

How did these problems affect the client? _____

Sexual Maturation History

At what age did the client begin puberty? _____

Were there any problems associated with the onset of menstrual period? _____ No _____ Yes

Does the client appear comfortable with the opposite sex? _____ No _____ Yes

Does the client date? _____ No _____ Yes

Has the client engaged in minimal dating? _____ No _____ Yes

Has the client had one or few long-standing relationships? _____ No _____ Yes

Has the client engaged in multiple relationships over a short period of time? _____ No _____ Yes

Has the client been sexually active? _____ No _____ Yes

Are you aware if the client uses protection? _____ No _____ Yes

Have you ever questioned the client's sexual orientation? _____ No _____ Yes

Have there ever been any homosexual contacts? _____ No _____ Yes

Have there ever been any pregnancies, miscarriages or abortion? _____ No _____ Yes

Does the client have any children? _____ No _____ Yes

Please give their ages and whereabouts: _____

Have there ever been any concerns about sexuality? _____ No _____ Yes

If yes, please explain: _____

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Educational History

Current Grade: _____ Chronological Age: _____ Cognitive Age Range: _____
 Educational Classification: _____ Expected Graduation Year: _____
 Expected Diploma (check all that apply) ___ GED ___ Local HS ___ IEP ___ Regents
 Does the Client Have an IEP? ___ Yes ___ No
 Does the Client Receive Section 504 Accommodations? ___ Yes ___ No

Current School District: _____
 Current School Name: _____
 Address: _____
 Phone #: _____ Fax #: _____
 Guidance Counselor's Name: _____ Phone #: _____

Classroom Placement (please check any that apply)

___ Regular Classes ___ Full Inclusion w/Resource Room ___ Partial Inclusion w/Specials
 ___ Home School ½ Tech Ed ½ ___ Full Alternative School ___ Alternative ½ Tech Ed ½
 ___ District Based Full Self-Contained
 ___ 15:1:1 ___ 12:1:1 ___ 8:1:1 ___ 6:1:1 ___ Has Individual Aid
 ___ BOCES ___ Eastern Suffolk ___ Western Suffolk ___ Nassau

Please check any services your child receives in school and indicate when (if past, for how long?)

	Yes	Duration	Past	Duration
Speech	_____	_____	_____	_____
Counseling (circle: individual, group or both)	_____	_____	_____	_____
PT	_____	_____	_____	_____
OT	_____	_____	_____	_____
Vision	_____	_____	_____	_____
Hearing	_____	_____	_____	_____
ESL	_____	_____	_____	_____
APE	_____	_____	_____	_____
Consultant Services	_____	_____	_____	_____
Bus Matron	_____	_____	_____	_____
Assistive Technology Use	_____	_____	_____	_____
If Assistive Technology is used please describe device: _____				

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Educational History Continued

Please describe the overall quality of the client's academic performance:

	Poor	Average	Excellent
Elementary school	_____	_____	_____
Middle School	_____	_____	_____
High School	_____	_____	_____
College	_____	_____	_____

Comments: _____

Did the client ever fail any subjects ? _____ Yes _____ No
If yes, what grade/s and class/courses? _____

How do you account for this failure? _____

School Challenges With:

	Yes	No
Attendance	_____	_____
Breaking rules	_____	_____
Conflict with staff	_____	_____
Conflict with peers	_____	_____
Lateness	_____	_____
Parent conferences called	_____	_____
ISS	_____	_____
OSS	_____	_____
Expulsion	_____	_____

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Educational History Continued

Has the client undergone any testing through the school district? _____ No _____ Yes
If no, do you wish to have your child referred for testing? _____ No _____ Yes
If yes, last date tested: _____
Do you require educational advocacy & consultation for your child? _____ No _____ Yes

If yes, please explain _____

Drug & Alcohol History

Does anyone in the family use or have a history of abusing drugs or alcohol? _____ No _____ Yes

If yes, please give relationship to client, type of drugs used, previous or current treatment, etc. _____

What drug or alcohol challenges does the client have?

Drug	Began Using	Current Use	Treatment Intervention Attempted
___ Alcohol	_____	_____	_____
___ Marijuana	_____	_____	_____
___ Angel Dust/PCP	_____	_____	_____
___ LSD	_____	_____	_____
___ Mescaline	_____	_____	_____
___ Volatile Solvents	_____	_____	_____
___ Heroin	_____	_____	_____
___ Methadone	_____	_____	_____
___ Cocaine/Coke	_____	_____	_____
___ Pills	_____	_____	_____
___ Other	_____	_____	_____

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Legal History

Is anyone in the family in legal or court difficulties?: ___No ___Yes If yes, please describe_____

Has the client ever been arrested?: ___No ___Yes If yes, please describe:_____

When?	What was the charge?	What was the outcome/sentence?

Has the client ever spent any time in jail? _____No _____Yes Describe:_____

Does the client have anything pending in the court? _____No _____Yes Describe:_____

Is the client on Probation/Parole? _____No _____Yes

What are the terms:_____

Probation/Parole Officer's Name:_____

Address:_____

Phone #:_____ Fax #:_____

Have there ever been any Child Protective Services reports made or involvement? ___No___Yes

If yes, please explain_____

Thank You for the Detailed Completion! It is Very Helpful!