

What is your child's primary reason for visiting LiveWell Psychological Services? _____

Please check all that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Sadness/Depression | <input type="checkbox"/> Medical/Health concerns | <input type="checkbox"/> Eating concerns |
| <input type="checkbox"/> Anxiety/Fears/Nervousness | <input type="checkbox"/> Sleep issues | <input type="checkbox"/> undereating |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> overeating |
| <input type="checkbox"/> Relationship Issues | <input type="checkbox"/> Anger | <input type="checkbox"/> bingeing |
| <input type="checkbox"/> Parenting concerns | <input type="checkbox"/> Underweight | <input type="checkbox"/> purging |
| <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Overweight | <input type="checkbox"/> overexercising |
| <input type="checkbox"/> Other, specify: _____ | | |

By signing below, I give permission for the minor named above to participate in evaluation and/or treatment with Laura Roberts, Ph.D. I certify that as the minor's custodial parent or legal guardian, I have the legal right to give such permission.

Signature

Date

Printed Name

Relationship to minor