



Private outpatient clinic

Centre for mental health

Clinic of Psychiatry and

Psychotherapy

Department of Psychiatry, Psychosomatics
and psychotherapy in childhood and adolescence

Medical director Prof. Dr. med. Renner

Osianderstraße 14

72076 Tübingen

Dear patients,

dear parents,

You have scheduled an appointment at our outpatient clinic. To ensure a smooth appointment process, please complete all the necessary documents and send them back to us in **full**. Afterwards we'll contact you for an appointment.

Due to high demand, the waiting time for an initial consultation is currently several months. We are aware of the importance of timely support, but kindly ask for your understanding regarding possible delays. For families outside the districts of Reutlingen and Tübingen, the waiting time may be even longer.

We are doing our best to use our resources effectively and to ensure the quality of our care.

Thank you very much for your understanding!

With kind regards,

Mrs. Dr. H. Spieles
Senior physician ambulance

Mrs. P. Schneider
Therapeutic outpatient management

Universitätsklinikum Tübingen

Anstalt des öffentlichen Rechts, Sitz Tübingen

Steuer-Nr. 86156/09402

USt.-ID: DE 146 889 674

Geissweg 3

72076 Tübingen

Tel. +49 7071 29-0

www.medizin.uni-tuebingen.de

Aufsichtsrat

Ulrich Steinbach (Vorsitzender)

Vorstand

Prof. Dr. Jens Maschmann (Vorsitzender)

Dr. Daniela Harsch (Stellv. Vorsitzende)

Prof. Dr. Ulrike Ernemann

Prof. Dr. Bernd Pichler

Klaus Tischler

Banken

Baden-Württembergische Bank Stuttgart:

(BLZ 600 501 01) Konto-Nr. 7477 5037 93

IBAN: DE 41 6005 0101 7477 5037 93

BIC (SWIFT-Code): SOLADEST600

Kreissparkasse Tübingen:

(BLZ 641 500 20) Konto-Nr. 14 144

IBAN: DE 79 6415 0020 0000 0141 44

BIC (SWIFT-Code): SOLADES1TUB



Application form for private outpatient clinic

Application for:

- ☐ First consulting
- ☐ Follow-up appointment (had an appointment in the last 12 months)
- ☐ Second opinion
- ☐ Partial inpatient treatment
- ☐ Full inpatient treatment

To be filled out by the ambulance:

Appointment with: _____

Date: _____

Centre for mental health

Clinic of Psychiatry and
Psychotherapy
Department of Psychiatry, Psychosomatics
and psychotherapy in childhood and
adolescence

**Medical director Prof. Dr. med.
Renner**

Osianderstraße 14
72076 Tübingen

Contact person:

Frau Steinhilber

Tel.: +49 (0)7071/ 29 62461

Fax: +49 (0)7071/ 29 25146

direktorat.kjp@med.uni-tuebingen.de

Emergency number:

Tel.: +49 (0)7071/ 29 62465

Child's information

Name: _____ **Surname:** _____

Date of birth: _____ ☐ male ☐ female ☐ non-binary

Child lives with ☐ both parents ☐ mother ☐ father ☐ _____

Contact information mother	Contact information father	Contact information residential group / foster family
Name:	Name:	Name:
Address:	Address:	Address:
Phone:	Phone:	Phone:
Mobil:	Mobil:	Mobil:
Mail:	Mail:	Mail:
Child custody <input type="checkbox"/> yes <input type="checkbox"/> no	Child custody <input type="checkbox"/> yes <input type="checkbox"/> no	Child custody <input type="checkbox"/> yes <input type="checkbox"/> no

Please note: If only one parent attends the appointment, the other parent must agree to the appointment in writing (form p. 3). In the case of separated parents with joint custody, the appointment cannot take place otherwise.

Insurance Information

Insurance: <input type="checkbox"/> private <input type="checkbox"/> statutory	
Name of insurance company:	Principal insurer, date of birth:
Video consultation – more information on p. 7	
We are willing to consider video consultation: <input type="checkbox"/> yes <input type="checkbox"/> no	Requirements: - Device with camera, microphone (PC, laptop, tablet, mobile phone), Internet access
Problems / symptoms / pre-diagnosis	
Further information – If so, please bring along previous findings	
First contact with <u>our</u> clinic?	<input type="checkbox"/> yes <input type="checkbox"/> no
Medical referral from children's hospital or Gynecology (DSD)?	<input type="checkbox"/> yes <input type="checkbox"/> no
Is your child currently taking any medication? If so, which one and how is it dosed?	<input type="checkbox"/> yes <input type="checkbox"/> no
Is there existing contact with another child and adolescent psychiatrist? If so, to whom? Is this contact ongoing?	<input type="checkbox"/> yes <input type="checkbox"/> no
Is there existing contact with another child and adolescent therapist? If so, to whom? Does this contact ongoing?	<input type="checkbox"/> yes <input type="checkbox"/> no
Has there already been an instance of inpatient child and adolescent psychiatric treatment? If so, when and where?	<input type="checkbox"/> yes <input type="checkbox"/> no
Has a psychological assessment already taken place? If so, where?	<input type="checkbox"/> yes <input type="checkbox"/> no



Declaration of consent of the absent parent with child custody

I hereby agree that my daughter / son

name of the child: _____ date of birth: _____

will be examined and treated in the Department of Psychiatry, Psychosomatic Medicine and Psychotherapy in Children and Adolescents of the University Hospital Tübingen.

I authorize

☐ the legally authorized mother: full name _____

☐ the legally authorized father: full name _____

☐ other persons (e.g. foster parents, residential group): name _____

to consent to the treatment and to make all necessary declarations.

In addition

☐ I authorize: full name _____

OR

☐ I **don't** authorize: full name _____

to undertake all necessary confidentiality obligations, such as for the pediatrician, other treating therapists, school, youth welfare and so on.

This declaration of consent may be revoked at any time in writing with immediate effect.

Name of the signing person

Place, date

Signature of the signing person

By phone I can be reached as follows: _____



Please arrive 20 minutes before your first appointment and bring copies of the following documents:

- ☐ Declaration of consent for the absent parent
- ☐ Yellow medical screening book
- ☐ Medical / psychosocial reports
- ☐ Treatment reports
- ☐ Informal school behavior report from the class teacher
- ☐ School reports of the last two years
- ☐ Youth welfare office reports

Please note that due to construction measures around the site, the parking situation and footpaths are significantly restricted. Please schedule enough time for the arrival.

Thank you for your understanding!



Directions



Arrival by bus:

Bus line 5:

Exit at the bus stop „Kliniken Tal“, cross the road on the other side and follow the signs to „Psychiatrische Klinik“. (footpath about 10 min.)

Bus line 13, 18 & 19:

Exit at the bus stop „Calwer Straße“. Please follow the signs to „Kliniken Tal“/ „Psychiatrische Klinik“. (footpath about 10 min.)

Arrival by car:

You can park along the road of Schnarrenbergstraße or you park at the car park P3 from the women's hospital (inner city clinics, Röntgenweg 2) or the car park „Altstadt König“ and follow the signs for „Psychiatrische Klinik“.

Please note that the staircases at the car park „Altstadt König“ are not available.

Declaration of consent to video and telephone consultation / confidentiality / contact for study requests

Dear parents, dear patients,

since we care about the best possible diagnosis and treatment of your child, we ask for your consent to the following points, which will make our work easier. Please refer to the back for further explanations.

Name of your child / youth _____, born the _____

For the period of diagnosis / treatment between my child or me and the staff of child and adolescent psychiatry (please mark as applicable)

- ☐ I agree to an instant shot of my child.
- ☐ I undertake to keep private information confidential to third parties.
- ☐ I agree that video and audio recordings may be recorded for diagnostic and therapeutic purposes.
- ☐ I agree that the video or audio recordings may be used for supervisory purposes within the child and youth psychiatry.

I agree to be contacted for study requests.

- ☐ Contact for study requests

By signing, I acknowledge that each of these declarations has been made voluntarily. I have been informed that I have the right to revoke this statement at any time, informally in writing or orally. Participation in therapeutic measures can of course also take place if I do not agree to the use of the recordings and data.

Tübingen, the _____

Signature of parents / legal guardians

Signature of parents / legal guardians

Signature of child / youth

Information sheet

Declaration of consent

Instant image for the file

The instant image is taken at one of the appointments in our outpatient clinic. The recording is primarily for the recognition of your child. The image is stored in the file during diagnosis and treatment. The images are not saved after completion of the treatment. We will destroy them appropriately. Under no circumstances will personal data be passed on to third parties.

Obligation of confidentiality

As part of the treatment of your child, you may receive information about fellow patients that is very personal and not intended to be passed on to third parties. By signing, you agree to remain silent about this information. The obligation of confidentiality applies throughout and after treatment.

Image and sound recordings

Our clinic has the possibility to take pictures and sound recordings (photos, videos, tape recordings and so on). The records are used in accordance with the applicable data protection regulations and are subject to medical confidentiality.

- Diagnostics and therapy: The primary aim of the image and sound recordings is to improve the quality of diagnosis, assessment and treatment. The quality of the treatment can be improved by a subsequent, precise examination in the interdisciplinary team.
- Supervision and internal teaching: As a university hospital we are a training hospital, which means the training of doctors, therapists, nurses and so on is an important part of our work. Appropriate admission in meetings can contribute to the quality of treatment.

Contact for study requests

We conduct scientific studies to learn more about the causes of psychiatric illnesses and to expand our existing knowledge. This enables us to constantly improve our treatment. You could help us to develop the medical expertise that people with mental disorders can benefit from in the future. We would be happy if we could contact you and your child in line with such studies. An employee would then contact you in order to present the study to you in detail. Our studies are reviewed and approved by the responsible ethics committee. The participation in studies is voluntary. It is possible to refuse to participate in a study at any time – without giving reasons and without restricting health care and rights. You may also revoke your consent to be contacted by us because of the studies at any time. Your data will be treated confidentially and will not be passed on.

Information sheet

Video and telephone consultation

Increasingly, video and telephone consultation are also being used in our company. They represent an additional offer for us. Personal appointments will continue furthermore. When registering and making an appointment, you can indicate whether video consultation is possible and feasible for you. If this is the case, you will usually receive a link via e-mail that allows you to access our video system.

To do this you need an internet-enabled device with microphone and camera. Please also check that your browser settings are enabled for this. Please ensure a quiet and well-lit environment for trouble-free implementation. Participation in the video consultation is voluntary and the use of the software is free of charge.

The program through which the video consultation is carried out is certified and approved by the health insurance companies. Data collection, processing and use for video consultation is carried out in accordance with the *Agreement on the Requirements for Technical Procedures for Video Consultation in accordance with Annex 31b to the Federal Coat Agreement – Doctors SGB V*.

We inform you hereby:

- The participation in the video consultation is voluntary for me / my child and staff of the clinic.
- To ensure data security and trouble-free operation on both sides, the video consultation takes place in enclosed rooms that ensure adequate privacy.
- At the beginning of the video consultation session there is a presentation on both sides of all the persons present in the room.
- Recordings of any kind are not permitted during video consultation.
- During the consultation, the employees inform the participants according to the requirements for the conduct of the video consultation (according to § 3 of the *Agreement on the Requirements for the Technical Procedures for the Video Consultation Hours according to Appendix 31 b of the Federal Coat Agreement – Doctors SGB V*).
- You consent to the collection, processing and use of my health data in the context of the video consultation by employees of the clinic; always in accordance with the applicable data protection regulations.
- You can revoke the consent of the employees of the clinic at any time without special formal requirements and deadlines.

MEDICAL HISTORY SHEET

Questionnaire completed on: _____ by: mother ☐ father ☐ _____

CHILD / YOUNG PERSON

First and last name

Gender

☐ male ☐ female ☐ _____

Date of birth

Place of birth

Child lives with

☐ biological parents ☐ foster parents
☐ biological mother ☐ residential group
☐ biological father ☐ adoptive parents
☐ _____

Current school form:

(primary school, community college, ...)

Grade:

Class teacher:

Name and address of school:

Phone number:

REASON FOR CONSULTATION AND AREAS OF CONCERN

Consultation initiated by:

☐ parents ☐ pediatrician / doctor ☐ psychotherapist: _____
☐ school ☐ kindergarten ☐ _____

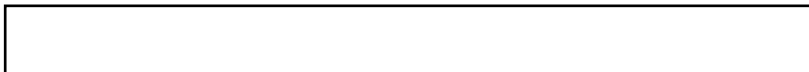
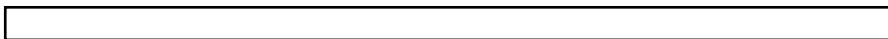
Main Concern / reason for consultation:

When did the problems first occur?

What are you most concerned about with regards to current problems?

What are your expectations from the consultation

HISTORY OF CHILD DEVELOPMENT		
COURSE OF PREGNANCY	Total number of pregnancies <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> ____	
	If the number of siblings differs from the number of pregnancies: What problems occurred?	
	Special events, struggles during the pregnancy (unplanned pregnancy, death of relatives, separation, moving, ...):	
	Complications during the course of pregnancy (bleeding, premature contractions, hospitalization, ...):	
	Risks: <input type="checkbox"/> smoking. If so, how many? <input type="text"/> <input type="checkbox"/> alcohol consumption. If so, how much? <input type="text"/> <input type="checkbox"/> drug consumption. If so, which drugs and how much? <input type="text"/>	
BIRTH	Pregnancy week at delivery:	
	Age of the mother at birth:	
	Complications during birth:	
	Birth weight: <input type="text"/>	Height: <input type="text"/>
	Head circumference:	APGAR:
POSTPARTUM COURSE	Complications after birth:	
	Was your child breastfed? <input type="checkbox"/> no <input type="checkbox"/> yes, until the <input type="text"/> <input type="text"/> month of life	



1

2

3

4

5

6

7

FREE TIME BEHAVIOR AND EVERYDAY FAMILY LIFE					
How often...	Everyday	About 3-5 times per week	About 1-2 times per week	Infrequent	Never
...does your child meet with other children (other than at school)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...does your child play outside?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
...is your child involved in regular leisure activities? (sports club, community work, musical instrument, ...)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What regular leisure activities does your child pursue? (e.g.: soccer, choir, scouts, ...)					
How much time does your child spend using media each day?					
	Less than an hour	About 1-2 hours	About 3-4 hours	More than 4 hours	Not at all
Mobile / smartphone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computer / tablet / internet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PlayStation / Wii / console	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much time does your child spent with electronic media in total? (TV, PC, Tablet, Handy, etc.) Monday to Friday: <input type="text"/> <input type="text"/> <input type="text"/> hours Weekend: <input type="text"/> <input type="text"/> <input type="text"/> hours					
DISEASES AND ALLERGIES					
Which diseases has your child had so far? <div style="border: 1px solid black; height: 30px; width: 100%;"></div>					
Which operations have been made so far? <div style="border: 1px solid black; height: 30px; width: 100%;"></div>					
Previous hospitalizations: 					

Chronic diseases	<input type="checkbox"/> asthma, since: _____ medication: _____ <input type="checkbox"/> others: _____ since: _____ medication: _____	
Allergies	<input type="checkbox"/> medicines: _____ <input type="checkbox"/> food: _____ <input type="checkbox"/> grasses / trees: _____ <input type="checkbox"/> animal hair: _____ <input type="checkbox"/> others: _____	
How long does your child sleep on average?		
Per day: <table border="1" style="display: inline-table; width: 30px; height: 20px; vertical-align: middle;"></table> <table border="1" style="display: inline-table; width: 30px; height: 20px; vertical-align: middle;"></table> At night: <table border="1" style="display: inline-table; width: 30px; height: 20px; vertical-align: middle;"></table> <table border="1" style="display: inline-table; width: 30px; height: 20px; vertical-align: middle;"></table>		
How long does it take your child to fall asleep? <input type="checkbox"/> 10-30 min. <input type="checkbox"/> 30-60 min. <input type="checkbox"/> 60-90 min. <input type="checkbox"/> 90 -120 min. <input type="checkbox"/> _____	Does your child often wake up at night? <input type="checkbox"/> no <input type="checkbox"/> yes, how often: <table border="1" style="display: inline-table; width: 60px; height: 20px; vertical-align: middle;"></table> <input type="checkbox"/> why (e.g. nightmares, restless sleep, ...): <table border="1" style="display: inline-table; width: 60px; height: 20px; vertical-align: middle;"></table> How do you react? <table border="1" style="width: 100%; height: 40px;"></table>	
FAMILY		
	<input type="checkbox"/> biological mother <input type="checkbox"/> adoptive mother <input type="checkbox"/> foster mother	<input type="checkbox"/> biological father <input type="checkbox"/> adoptive father <input type="checkbox"/> foster father
First and last name		
Current address		
Phone number		
Mobile phone number		
Date of birth (age)		

Place of birth		
Nationality		
Learned occupation		
Current occupation		
Work scope hours/week		
Highest general educational qualification	<input type="checkbox"/> not yet graduated / still student <input type="checkbox"/> graduated after a maximum of 7 years of school attendance <input type="checkbox"/> Haupt-/Volksschule <input type="checkbox"/> Realschule / Middle School Certificate / Polytechnic High School <input type="checkbox"/> A-Levels, general or subject-specific university entrance qualification, extended secondary school, university entrance qualification / advanced technical college entrance qualification, city college <input type="checkbox"/> other qualifications (e.g. obtained abroad): _____	<input type="checkbox"/> not yet graduated / still student <input type="checkbox"/> graduated after a maximum of 7 years of school attendance <input type="checkbox"/> Haupt-/Volksschule <input type="checkbox"/> Realschule / Middle School Certificate / Polytechnic High School <input type="checkbox"/> A-Levels, general or subject-specific university entrance qualification, extended secondary school, university entrance qualification / advanced technical college entrance qualification, city college <input type="checkbox"/> other qualifications (e.g. obtained abroad): _____
Highest professional qualification	<input type="checkbox"/> no degree, still in vocational training, e.g. student, trainee, year of vocational preparation, internship <input type="checkbox"/> no professional qualifications and no apprenticeship <input type="checkbox"/> apprenticeship, i.e. vocational training <input type="checkbox"/> training at vocational school, commercial school, i.e. vocational schooling <input type="checkbox"/> technical school, e.g. master's school, technical school, vocational or technical academy <input type="checkbox"/> University of Applied Sciences, Engineering School <input type="checkbox"/> University or college <input type="checkbox"/> other school leaving qualifications (e.g. obtained abroad): _____	<input type="checkbox"/> no degree, still in vocational training, e.g. student, trainee, year of vocational preparation, internship <input type="checkbox"/> no professional qualifications and no apprenticeship <input type="checkbox"/> apprenticeship, i.e. vocational training <input type="checkbox"/> training at vocational school, commercial school, i.e. vocational schooling <input type="checkbox"/> technical school, e.g. master's school, technical school, vocational or technical academy <input type="checkbox"/> University of Applied Sciences, Engineering School <input type="checkbox"/> University or college <input type="checkbox"/> other school leaving qualifications (e.g. obtained abroad): _____
Gainful employment	<input type="checkbox"/> working fulltime <input type="checkbox"/> working part-time <input type="checkbox"/> marginally employed <input type="checkbox"/> unemployed <input type="checkbox"/> retired / early retirement since: _____	<input type="checkbox"/> working fulltime <input type="checkbox"/> working part-time <input type="checkbox"/> marginally employed <input type="checkbox"/> unemployed <input type="checkbox"/> retired / early retirement since: _____

Professional status (if currently not / no longer employed: professional status you held last)	<input type="checkbox"/> employee <input type="checkbox"/> worker <input type="checkbox"/> civil servant <input type="checkbox"/> farmer in main occupation <input type="checkbox"/> self-employed without employees <input type="checkbox"/> self-employed with employees <input type="checkbox"/> working for the family (unpaid) <input type="checkbox"/> trainee, volunteer <input type="checkbox"/> voluntary military service or federal voluntary service <input type="checkbox"/> voluntary social / environmental / cultural year <input type="checkbox"/> never been in an employment	<input type="checkbox"/> employee <input type="checkbox"/> worker <input type="checkbox"/> civil servant <input type="checkbox"/> farmer in main occupation <input type="checkbox"/> self-employed without employees <input type="checkbox"/> self-employed with employees <input type="checkbox"/> working for the family (unpaid) <input type="checkbox"/> trainee, volunteer <input type="checkbox"/> voluntary military service or federal voluntary service <input type="checkbox"/> voluntary social / environmental / cultural year <input type="checkbox"/> never been in an employment		
Details of management and leadership duties/ authority to give instructions to employees who are not apprentices	<input type="checkbox"/> yes, as a manager (with decision-making authority over personnel, budget and strategy) <input type="checkbox"/> yes, as supervisor (guiding and supervising staff, distributing and controlling work) <input type="checkbox"/> no	<input type="checkbox"/> yes, as a manager (with decision-making authority over personnel, budget and strategy) <input type="checkbox"/> yes, as supervisor (guiding and supervising staff, distributing and controlling work) <input type="checkbox"/> no		
Custody	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no		
LIVING SITUATION OF PARENTS				
<table border="1" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> living together, since: _____ <input type="checkbox"/> married, since: _____ <input type="checkbox"/> living separately, since: _____ </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> divorced, since: _____ <input type="checkbox"/> other family constellation: _____ </td> </tr> </table>			<input type="checkbox"/> living together, since: _____ <input type="checkbox"/> married, since: _____ <input type="checkbox"/> living separately, since: _____	<input type="checkbox"/> divorced, since: _____ <input type="checkbox"/> other family constellation: _____
<input type="checkbox"/> living together, since: _____ <input type="checkbox"/> married, since: _____ <input type="checkbox"/> living separately, since: _____	<input type="checkbox"/> divorced, since: _____ <input type="checkbox"/> other family constellation: _____			
FOR PARENTS LIVING SEPARATELY				
	Partner of mother	Partner of father		
First and last name				
Date of birth (age)				
Place of birth				
Nationality				
Partnership since				
Living together since				
Learned occupation				

Current occupation		
Working Hours (hours/week)		
Highest general educational qualification	<input type="checkbox"/> not yet graduated / still student <input type="checkbox"/> graduated after a maximum of 7 years of school attendance <input type="checkbox"/> Haupt-/Volksschule <input type="checkbox"/> Realschule / Middle School Certificate / Polytechnic High School <input type="checkbox"/> A-Levels, general or subject-specific university entrance qualification, extended secondary school, university entrance qualification / advanced technical college entrance qualification, city college <input type="checkbox"/> other graduations (e.g. obtained abroad): _____	<input type="checkbox"/> not yet graduated / still student <input type="checkbox"/> graduated after a maximum of 7 years of school attendance <input type="checkbox"/> Haupt-/Volksschule <input type="checkbox"/> Realschule / Middle School Certificate / Polytechnic High School <input type="checkbox"/> A-Levels, general or subject-specific university entrance qualification, extended secondary school, university entrance qualification / advanced technical college entrance qualification, city college <input type="checkbox"/> other graduations (e.g. obtained abroad): _____
Highest professional qualification	<input type="checkbox"/> no degree, still in vocational training, e.g. student, trainee, year of vocational preparation, internship <input type="checkbox"/> no professional qualifications and no apprenticeship <input type="checkbox"/> apprenticeship, i.e. vocational training <input type="checkbox"/> training at vocational school, commercial school, i.e. vocational schooling <input type="checkbox"/> technical school, e.g. master's school, technical school, vocational or technical academy <input type="checkbox"/> University of Applied Sciences, Engineering School <input type="checkbox"/> University or college <input type="checkbox"/> other school leaving qualifications (e.g. obtained abroad): _____	<input type="checkbox"/> no degree, still in vocational training, e.g. student, trainee, year of vocational preparation, internship <input type="checkbox"/> no professional qualifications and no apprenticeship <input type="checkbox"/> apprenticeship, i.e. vocational training <input type="checkbox"/> training at vocational school, commercial school, i.e. vocational schooling <input type="checkbox"/> technical school, e.g. master's school, technical school, vocational or technical academy <input type="checkbox"/> University of Applied Sciences, Engineering School <input type="checkbox"/> University or college <input type="checkbox"/> other school leaving qualifications (e.g. obtained abroad): _____
Gainful employment	<input type="checkbox"/> working fulltime <input type="checkbox"/> working part-time <input type="checkbox"/> marginally employed <input type="checkbox"/> unemployed <input type="checkbox"/> retired / early retirement since: <input type="text"/>	<input type="checkbox"/> working fulltime <input type="checkbox"/> working part-time <input type="checkbox"/> marginally employed <input type="checkbox"/> unemployed <input type="checkbox"/> retired / early retirement since: <input type="text"/>
Professional status (if currently not / no longer employed: professional status you held last)	<input type="checkbox"/> employee <input type="checkbox"/> worker <input type="checkbox"/> civil servant <input type="checkbox"/> farmer in main occupation <input type="checkbox"/> self-employed without employees	<input type="checkbox"/> employee <input type="checkbox"/> worker <input type="checkbox"/> civil servant <input type="checkbox"/> farmer in main occupation <input type="checkbox"/> self-employed without employees

	<input type="checkbox"/> self-employed with employees <input type="checkbox"/> working for the family (unpaid) <input type="checkbox"/> trainee, volunteer <input type="checkbox"/> Voluntary military service or federal voluntary service <input type="checkbox"/> Voluntary social / environmental / cultural year <input type="checkbox"/> never been in an employment	<input type="checkbox"/> self-employed with employees <input type="checkbox"/> working for the family (unpaid) <input type="checkbox"/> trainee, volunteer <input type="checkbox"/> Voluntary military service or federal voluntary service <input type="checkbox"/> Voluntary social / environmental / cultural year <input type="checkbox"/> never been in an employment
Details of management and leadership duties/ authority to give instructions to employees who are not apprentices	<input type="checkbox"/> yes, as a manager (with decision-making authority over personnel, budget and strategy) <input type="checkbox"/> yes, as supervisor (guiding and supervising staff, distributing and controlling work) <input type="checkbox"/> no	<input type="checkbox"/> yes, as a manager (with decision-making authority over personnel, budget and strategy) <input type="checkbox"/> yes, as supervisor (guiding and supervising staff, distributing and controlling work) <input type="checkbox"/> no

RELATIONSHIP ARRANGEMENTS (IN CASE OF SEPARATED PARENTS)

☐ There is contact with the non-resident parent. How often?

☐ There is **no** contact with the biological father/mother.

Since when and why?

Contact arrangements were arranged by:

☐ parents with each other / by mutual agreement

☐ advice center

☐ Youth welfare office

☐ court

☐

How satisfied are you with the existing contact arrangements?

☐ very satisfied

☐ satisfied

☐ unsatisfied

Other living situation:

☐ lives with the grandparents

main contact person:

☐ lives in a residential group

SIBLINGS

	1	2	3	4	5
First name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Last name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Relationship	<input type="checkbox"/> full-siblings <input type="checkbox"/> half-siblings <input type="checkbox"/> step-siblings	<input type="checkbox"/> full-siblings <input type="checkbox"/> half-siblings <input type="checkbox"/> step-siblings	<input type="checkbox"/> full-siblings <input type="checkbox"/> half-siblings <input type="checkbox"/> step-siblings	<input type="checkbox"/> full-siblings <input type="checkbox"/> half-siblings <input type="checkbox"/> step-siblings	<input type="checkbox"/> full-siblings <input type="checkbox"/> half-siblings <input type="checkbox"/> step-siblings
In case of half-siblings / step-siblings	<input type="checkbox"/> maternal <input type="checkbox"/> paternal	<input type="checkbox"/> maternal <input type="checkbox"/> paternal	<input type="checkbox"/> maternal <input type="checkbox"/> paternal	<input type="checkbox"/> maternal <input type="checkbox"/> paternal	<input type="checkbox"/> maternal <input type="checkbox"/> paternal

Class; type of school or school leaving certificate					
Apprenticeship /occupation					
Are there any problems, abnormalities or diseases? If so, which ones?	Physical: <div></div> Mental / behavioral: <div></div>	Physical: <div></div> Mental / behavioral: <div></div>	Physical: <div></div> Mental / behavioral: <div></div>	Physical: <div></div> Mental / behavioral: <div></div>	Physical: <div></div> Mental / behavioral: <div></div>
Does the child / youth live in the same household? (yes / no)					
KNOWN DISEASES AND ABNORMALITIES IN THE FAMILY					
Which physical and mental illnesses are known to occur in the family?	Biological father	Biological mother	Grandma (maternal / paternal)	Grandpa (maternal / paternal)	Other relatives
	<u>physical:</u> <div></div> <u>mental:</u> <div></div>	<u>physical:</u> <div></div> <u>mental:</u> <div></div>	<u>physical:</u> m: <div></div> p: <div></div> <u>mental:</u> m: <div></div> p: <div></div>	<u>physical:</u> m: <div></div> p: <div></div> <u>mental:</u> m: <div></div> p: <div></div>	<u>physical:</u> m: <div></div> p: <div></div> <u>mental:</u> m: <div></div> p: <div></div>
Attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Completed suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PREVIOUS APPROACHES / TREATMENTS					
What recommendations have been made so far (by pediatrician, school, therapist, ...)?					
What have you or others (e.g. school, ...) already tried to improve the problematic behavior?					

Previous treatments / therapies			
(e.g.: early education, psychotherapy, occupational therapy, learning therapy, medication)			
Type of treatment (In case of therapy: type and name of therapist/doctor in case of medication: name and dose of medication)	Age (at beginning)	Duration (months and frequency/ number of contacts)	Where / What exactly?
Occupational therapy			
Speech therapy			
Learning therapy			
Psychological information center			
Outpatient psychotherapy			
Type of treatment (In case of therapy: type and name of therapist/doctor in case of medication: name and dose of medication)	Age (at beginning)	Duration (months and frequency/ number of contacts)	Where / What exactly?
Child psychiatric treatment			
psychotherapy in a day clinic			
Inpatient psychotherapy			
Outpatient crisis intervention / emergency consultation			
Inpatient crisis intervention			
Medication			Name: <input type="text"/> Dose: <input type="text"/>
Other treatments			
Previous diagnoses (if known):			
YOUTH WELFARE OFFICE			
Is or your family or has your family been in contact with youth welfare services? <input type="checkbox"/> no <input type="checkbox"/> yes			

If so, which youth welfare office was / is responsible? <input type="checkbox"/> Tübingen <input type="checkbox"/> Reutlingen <input type="checkbox"/> _____ Responsible contact person: Name: _____ Phone number: _____	
Type of assistance provided by youth welfare services: <input type="checkbox"/> Counseling <input type="checkbox"/> Aufsuchende sozialpädagogische Familienhilfe (SPFH) <input type="checkbox"/> Educational supervisor <input type="checkbox"/> Intensive case-by-case assistance <input type="checkbox"/> Family therapy <input type="checkbox"/> Day care group <input type="checkbox"/> Residential group <input type="checkbox"/> <input style="width: 150px; height: 15px; border: 1px solid black;" type="text"/> <input type="checkbox"/> <input style="width: 150px; height: 15px; border: 1px solid black;" type="text"/>	Start date and scope (hours per week) of assistance: <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> <input style="width: 150px; height: 15px; border: 1px solid black;" type="text"/> <input type="checkbox"/> <input style="width: 150px; height: 15px; border: 1px solid black;" type="text"/> <input type="checkbox"/> <input style="width: 150px; height: 15px; border: 1px solid black;" type="text"/> <input type="checkbox"/> <input style="width: 150px; height: 15px; border: 1px solid black;" type="text"/> <input type="checkbox"/> <input style="width: 150px; height: 15px; border: 1px solid black;" type="text"/> <input type="checkbox"/> <input style="width: 150px; height: 15px; border: 1px solid black;" type="text"/> <input type="checkbox"/> <input style="width: 150px; height: 15px; border: 1px solid black;" type="text"/>
Has your child had a hospitalization of four days or more in the past 12 months?	
<input type="checkbox"/> no <input type="checkbox"/> yes	
If your child is to be considered for an inpatient stay in our clinic or a stay in our day clinic, we kindly ask you to check their vaccination certificate with your pediatrician before admission. If there are upcoming vaccinations, please arrange for them to be taken immediately. Please bring the vaccination certificate with you to the preliminary interview.	
Are there things that have not been mentioned so far but could be important in order to better understand the problem?	
If you wish, you can list your expectations here:	

Thank you very much!