HERON RIDGE ASSOCIATES
PERSPECTIVES COUNSELING CENTERS

Dx_____ **SCREENING INFORMATION**

Please Print Clearly

THIS SHEET MUST BE FILLED IN COMPLETELY

Readmit: __Yes __No

Date_____ Client's Social Security #_____ Case #_____

Client's Last Name_____ First Name_____MI_____

Address_____ City_____ State_____ Zip_____

Telephone (Home)_____ (Work)_____ (Cell) _____

Ok to leave messages? Home: ___yes ___no Work: ___yes ___no Cell: ___yes ___no

Birthdate_____/_____/_____ Age_____ Gender __F __M Race _____

Adult's Email address (used for marketing purposes only) _____

Name of Parent/Guardian_____ Phone_____

Address_____ City_____ State_____ Zip_____

Emergency Information

In case of emergency, contact:

Name (1) _____ Relationship_____ Phone_____

Address_____ City_____ State_____ Zip_____

Name (2) _____ Relationship_____ Phone_____

Address_____ City_____ State_____ Zip_____

Physician_____ Phone_____

Address_____ City_____ State_____ Zip_____

Other Physician_____ Phone_____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place_____ Occupation_____ Hrs____

Spouse: Place_____ Occupation_____ Hrs____

Insurance Information

Primary Insurance_____

Contract/ID#_____

Group/Acct#_____

Subscriber_____

Subscriber Social Security #_____

Subscriber Date of Birth _____

Client's relationship to Subscriber (1)

__Self __Spouse __Son/Daughter

Secondary Insurance_____

Contract/ID#_____

Group/Acct#_____

Subscriber_____

Subscriber Social Security #_____

Subscriber Date of Birth_____

Client's relationship to Subscriber (2)

__Self __Spouse __Son/Daughter

Referral Source

How did you hear of our clinic (or from whom)?_____

Address_____ City_____ State_____ Zip_____

Phone_____

Heron Ridge Associates
Perspectives Counseling Centers

Personal History
-Child and Adolescent-

Client's Name _____ **Date** _____

Address _____ City _____ State _____ Zip _____
Form completed by: __ Parent __ Child

If you need any more space for any of the following questions please use the back of the sheet.

Primary reason(s) for seeking services

___ Anger management	____ Anxiety	___ Coping	____ Depression
___ Eating disorder	____ Fear/phobias	___ Mental confusion	____ Sexual concerns
___ Sleeping problems	____ Addictive behaviors	___ Alcohol/drugs	____ Hyperactivity
___ Self Injury	____ Self Esteem	___ Impulsivity	____ Behavior Problems
___ Distractibility			

Other mental health concerns (specify) _____

_____

How long have these symptoms been present? _____

What are your goals for the child's therapy? _____

_____

What are your child's goals for therapy?_____

_____

What family involvement would you like to see in the therapy? _____

What areas of your life are being affected by the above?

Social
__ Unable to form or maintain friendships
__ Withdrawal from family and friends (excessive desire to be alone)
__ Increased conflict with others
__ Loss of interest in social activities
__ Phobia
__ Poor social skills
__ Attachment problems

Occupational
__ Unable to maintain job
__ Absenteeism
__ Conflicts with co-workers
__ Tardiness
__ Reduced productivity
__ Disciplinary action for poor performance

Academic
__ Failing grades
__ Skipping school
__ Tardiness
__ Detention
__ Reduced productivity at school
__ Homework problems
__ Fighting/conflicts with students/teachers

Physical
__ Decreased energy/fatigue
__ Difficulty getting out of bed or insomnia
__ Decreased/increased appetite
__ Substantial weight loss or gain
__ Psychosomatic complaints (headaches, stomachaches, etc.)
__ Frequent illness
__ Bed wetting

Affective Distress
__ Crying spells
__ Mood swings
__ Concentration problems
__ Disorganized thoughts
__ Feeling overwhelmed with emotions

Affective Distress Continued
__ Worrying that interferes with the ability to concentrate
__ Memory problems
__ Anger/rage

Behavioral/Emotional

Please check any of the following that are typical for your child:

___ Affectionate
___ Aggressive (__verbal __physical)
___ Alcohol problems
___ Angry
___ Anxiety
___ Attachment to dolls
___ Avoids adults
___ Bedwetting
___ Blinking, jerking
___ Bizarre behavior
___ Bullies, threatens
___ Careless, reckless
___ Chest pains
___ Clumsy
___ Confident
___ Cooperative
___ Computer addiction
___ Defiant
___ Depression
___ Destructive
___ Difficulty speaking
___ Dizziness
___ Drug dependence
___ Eating disorder
___ Enthusiastic
___ Excessive masturbation
___ Expects failure
___ Fatigue
___ Fearful
___ Quarrels
___ Frustrated easily
___ Gambling
___ Generous
___ Hallucinations
___ Head banging
___ Heart problems
___ Hopelessness
___ Hurts animals
___ Imaginary friends
___ Impulsive
___ Irritable
___ Lazy
___ Learning problems
___ Lies frequently
___ Listens to reason
___ Loner
___ Low self-esteem
___ Messy
___ Moody
___ Nightmares
___ Obedient
___ Often sick
___ Oppositional
___ Over active
___ Over weight
___ Panic attacks
___ Phobias
___ Poor appetite
___ Psychiatric problems
___ Sad
___ Selfish
___ Separation anxiety
___ Sets fires
___ Sexual addiction
___ Sexual acting out
___ Shares
___ Sick often
___ Short attention span
___ Shy, timid
___ Sleeping problems
___ Slow moving
___ Soiling
___ Speech problems
___ Steals
___ Stomach aches
___ Suicidal threats
___ Suicidal attempts
___ Talks back
___ Teeth grinding
___ Thumb sucking
___ Tics or twitching
___ Unsafe behaviors
___ Unusual thinking
___ Weight loss
___ Withdrawn
___ Worries excessively
___ Sleeping in bed problems
___ Frequent injuries
___ Other _____

Please describe any of the above (or other) concerns _____

_____

_____

_____

Has the child/adolescent experienced death? (friends, family pets, other) __No __Yes

At what age? _____ If Yes, describe the child's/adolescent's reaction _____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)

__No __Yes If Yes, describe_____

Do you suspect your child is using any alcohol or drugs? (including illicit, prescription, over-the-counter or cigarettes) __ No __ Yes Explain _____

_____

How are problem behaviors generally handled?_____
_____

Counseling/Prior Treatment History

Information about child/adolescent (past and present)

	Yes	No	When	Where	Overall experience
Mental health counseling	___	___	_____	_____	_____
	___	___	_____	_____	_____
Psychiatrist for medication	___	___	_____	_____	_____
Suicidal/Homicidal thoughts	___	___	_____	_____	_____
Suicidal/Homicidal attempts	___	___	_____	_____	_____
Drug/Alcohol treatment	___	___	_____	_____	_____
Mental Health	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	___	___	_____	_____	_____

Any immediate family in treatment currently? If yes, whom and where? _____

Parental Information

With whom does the child live at this time? _____
Are parents divorced or separated? __ No __ Yes (when?) _____
If Yes, who has legal/physical custody? _____
Amount of time spent with each parent _____
Were the child's parents ever married? __No __Yes
****Bring custody paperwork to first session if parents are divorced**
Who handles responsibility for your child in the following areas?
School __Mother __Father __Shared __Other (specify) _____
Health __Mother __Father __Shared __Other (specify) _____
Problem behavior __Mother __Father __Shared __Other (specify) _____

Discipline Techniques: _____
Quality of Parents' Marriage: __ Good __ Average __ Poor
Does arguing happen in front of the child? __ No ___ Yes
Is there any significant information about the parents' relationship or treatment toward the child that might be beneficial to know for counseling? __ No __ Yes If Yes, describe _____
_____

Client's Mother

Name _____ Age _____ Occupation _____ ___ FT ___ PT
Where employed _____ Work phone _____
Mother's education _____
Is the child currently living with the mother? __Yes __No If No, which of the following:
__Step-parent __Adoptive parent __Foster home __Other (specify) _____
Is there anything notable, unusual or stressful about the child's relationship with the mother?
___ No ___ Yes If Yes, please explain _____
_____
How is the child disciplined by the mother (e.g. grounding, spanking)? _____
For what reasons is the child disciplined by the mother? _____

Client's Father

Name _____ Age _____ Occupation _____ ___ FT ___ PT
Where employed _____ Work phone _____
Father's education _____
Is the child currently living with the father? __Yes __No If No, which of the following:
__Step-parent __Adoptive parent __Foster home __Other (specify) _____
Is there anything notable, unusual or stressful about the child's relationship with the father?
___ No ___ Yes If Yes, please explain _____
_____

How is the child disciplined by the father (eg. grounding, spanking)? _____
For what reasons is the child disciplined by the father? _____

Client's Siblings and Others Who Live in the Household

Names of Siblings	Age	Gender	Lives	Quality of relationship with the client
_____	___	___ F ___ M	__ home __away	___ poor __ average __ good
_____	___	___ F ___ M	__ home __ away	___ poor __ average __ good
_____	___	___ F ___ M	__ home __ away	___ poor __ average __ good

Others living in the household	Age	Gender	Relationship (e.g., cousin, foster child)	Quality of relationship with client
_____	___	___ F ___ M	_____	___ poor __ average __ good
_____	___	___ F ___ M	_____	___ poor __ average __ good
_____	___	___ F ___ M	_____	___ poor __ average __ good

Comments _____

_____

Childhood/Adolescent History

Pregnancy/Birth

Has the child's mother had any occurrences of miscarriages or stillborns? __Yes __No
If Yes, describe _____
Was the pregnancy with child planned? __Yes __No Length of pregnancy _____
Mother's age at child's birth ___ Father's age at child's birth___ Child # ____of ____ total children.
How many pounds did the mother gain during the pregnancy? ____
While pregnant did the mother smoke? __No __Yes If Yes, what amount _____
Did the mother use drugs or alcohol? __No __Yes If Yes, type/amount _____
While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication) __No __Yes If Yes, describe _____
Length of labor _____ Induced ___ Yes ___ No Caesarean? __ Yes __ No
Baby's birth weight _____ Baby's birth length ___
Describe any physical or emotional complications with the delivery _____
_____
Describe any complications for the mother or the baby after the birth _____
_____
Length of hospitalization Mother _____ Baby _____

Infancy/Toddlerhood Check all which apply

___ Breast fed	____ Milk allergies	___ Vomiting	____ Diarrhea
___ Bottle fed	____ Rashes	___ Colic	____ Constipation
___ Not cuddly	____ Cried often	___ Rarely cried	____ Overactive
___ Resisted solid food	____ Trouble sleeping	___ Irritable when awakened	____ Lethargic

Developmental History Please note the age at which the following behaviors took place

Sat alone _____ Dressed self _____
Took 1st steps _____ Tied shoe laces _____
Spoke words _____ Rode two-wheeled bike _____
Spoke sentences _____ Toilet trained _____
Weaned _____ Dry during day _____
Fed self _____ Dry during night _____
Compared with others in the family, child's development was: __slow __average __fast

Age for developments (fill in where applicable)
Began puberty _____ Menstruation _____
Voice change _____ Convulsions _____
Breast development _____ Injuries or hospitalizations _____
Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect)
_____

Any history of being abused by others? __No __Yes If Yes, what type(s) of abuse?
__Emotional __Sexual __Physical __Verbal __Other (Describe)_____
What age was the child when he or she was abused? _____

Any history of child abusing others? __ No __ Yes If Yes, describe _____

Is there a history of any important separations, losses, deaths, traumas? _____

_____

Immunization record (check immunizations the child/adolescent has received)

	DPT	Polio		
2 months	___	___	15 months	__MMR (Measles, Mumps, Rubella)
4 months	___	___	24 months	__HBPV (Hib)
6 months	___	___	Prior to school	__ HepB
18 months	___	___		
4–5 years	___	___		

Child's Peer Relationships

___ Spontaneous ____ Follower ___ Leader ____ Difficulty making friends
___ Makes friends easily ____ Long-time friends ___ Shares easily ___ Bullying/being bullied
___ Other (describe) _____
Social Skills: __ Good __ Average __ Poor

Cultural/Ethnic

To which cultural or ethnic group, if any, does your child belong?_____
Is he/she experiencing any problems due to cultural or ethnic issues? __No __Yes
If Yes, describe_____
Other cultural/ethnic information_____

Spiritual/Religious

How important to you are spiritual matters to your child? __Not at all __Little __Moderate __Much
Is he/she affiliated with a spiritual or religious group? __No __ Yes
If Yes, describe _____
Was he/she raised within a spiritual or religious group? __No __Yes
If Yes, describe_____
Would you like your spiritual/religious beliefs incorporated into your child's counseling? __ No __Yes
If Yes, describe_____

Child's Current Legal Status

Is your child mandated for treatment? __ No __ Yes
If yes, explain: _____
Is your child involved in any active cases (traffic, civil, criminal)? __ No __Yes
If Yes, please describe and indicate the court and hearing/trial dates and charges_____
_____
Are you presently on probation or parole? __No __Yes
If Yes, please describe_____

Child's Past Legal History

Traffic violations ____ Yes ___ No DWI, DUI, etc. ___ Yes ___ No
Criminal involvement ____ Yes ___ No Civil involvement ___ Yes ___ No
If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

Education

Current school _____ School phone number _____
Type of school __Public __Private __ Home schooled
Grade _____ Teacher _____ School Counselor _____
In special education or gifted program? __No __Yes If Yes, describe_____
Has child ever been held back in school? __ No __Yes If Yes, describe _____
Which subjects does the child enjoy in school? _____
Which subjects does the child dislike in school? _____
What grades does the child usually receive in school? _____
Have there been any recent changes in the child's grades? __ No __Yes
If Yes, describe _____
Has the child been tested psychologically? __No __Yes
If Yes, describe (and bring reports) _____
Current IEP/504 Plan in place at school? __ Yes __ No
Literacy Level (if known) __ Limited (0-275) __ Minimal (276 – 325) __ High (326 and higher)

Feelings about School Work Check the descriptions that specifically relate to your child.

___ Anxious ___ Passive ___ Enthusiastic ___ Fearful
___ Eager ___ No expression ___ Bored ___ Rebellious
___ Other (describe) _____

Approach to School Work

___ Organized ___ Industrious ___ Responsible ___ Interested
___ Self-directed ___ No initiative ___ Refuses ___ Does only what is expected
___ Sloppy ___ Disorganized ___ Cooperative ___ Does not complete assignments
___ Other (describe) _____

Performance in School (Parent's/Guardian's Opinion)

__Satisfactory __Underachiever __Overachiever __ Other (Describe)_____
Would you like to have the therapist have communication with the school? __ Yes __ No

Work

If the child is involved in a vocational program or works a job, please fill in the following
What is the child's attitude toward work? __Poor __Average __Good __Excellent
Current employer _____ Position _____ Hours per week _____
How have the child's grades in school been affected since working? __ Lower __Same __Higher

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts)

Activities	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Media/Electronics Use:

__ Cellphone __ Texting __ Computer __ Facebook __ Video Games

__ Other (Describe) _____

Number of Hours/Day _____

Do you have conflicts regarding this? (Describe) _____

Current Annual Income: $_____Personal income $_____Household Income

Parents' Work: Father: __Full Time __Part Time __Temp __Laid-off __Disabled __Retired __ Student
Mother __Full Time __Part Time __Temp __Laid-off __Disabled __Retired __ Student

Medical/Physical Health Condition (Check any problem areas your child has or has had)

For each illness listed below, choose a single answer that best describes your child's health history:

Condition	Currently	In Past	Never	Condition	Currently	In Past	Never
Anemia				Miscarriage			
Appetite Change				Loss of Consciousness			
Asthma				Memory Loss			
Arthritis				Multiple Sclerosis			
Back Pain				Numbness			
Blood In Stool				Pain (Daily, Longer than 2 weeks)			
Blurred Vision				Palpitations			
Caffeine Use				Paralysis			
Chest Pain				Rheumatic Fever			
Chicken Pox				Seizures			
Chronic Cough				Shortness of Breath			
Colitis or Irritable Bowel				Skin Disease			
Confusion or Disorientation				Sleep Apnea			
Constipation				Sleep Difficulties			
Diabetes				Stroke or TIA			
Diarrhea				Swallowing Difficulty			
Dizziness				Dental Problems			
Emphysema				Thyroid Disease			
Fainting				Tuberculosis			
Glaucoma				Ulcers or Indigestion			
Head Injury				Urination Difficulty			
Headaches (Frequent)				Sexually Transmitted Disease			
Hearing Loss				HIV/AIDS/ Weakness			
Heart Disease				Recent Weight Gain			
Hepatitis				Recent Weight Loss			
Malnutrition				Other:			

Any other medical conditions that the therapist should be aware of? _____

_____

Do any of these illnesses significantly challenge or limit your child's ability to function at school or at home?
If yes, please provide details: _____

_____

List any other of your child's current health concerns:_____

_____

List any recent health or physical changes:_____

_____

Please list all of your child's current prescription and non-prescription (over-the-counter) medications:

Name of your current medicine	What do you use it for?	When did you begin taking it?	What is the strength of each tablet or capsule?	What dose do you take, and how often?	Name of prescribing physician
Example: "Amoxicillin"	Strep Throat	11/1/2017	1 table = 250 mg.	1 tablet, 3 times a day at meals	Dr. Smith

Please list all psychiatric medications that your child has taken in the past:

Name of your previous medicine	What did you use it for?	How long did you take it?	When did you stop taking it?	Why was it stopped?	Was the medication effective?
Example: "Lexapro"	Anxiety	6 months	9 months ago	Improved condition	Yes/ No

Please list all nutritional and herbal supplements that your child currently takes:

_____

Medication Allergies: _____
Does your child take psychiatric medication? If yes, which type? _____
Who prescribes these medications? __ Primary Care Physician ___ Psychiatrist
Describe child's overall compliance with the above medications _____

Hospital of choice _____ Phone_____
Address _____

Most recent examinations

Type of examination	Date of most recent visit	Results
Physical examination	_____	_____
Dental examination	_____	_____
Vision examination	_____	_____
Hearing examination	_____	_____

Physical Activity Level: ___ Low ___ Medium ___ High

Physical Family Health History

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply

___ Allergies
___ Anemia
___ Asthma
___ Bleeding tendency
___ Blindness
___ Cancer
___ Cerebral Palsy
___ Cleft lips
___ Cleft palate
__ Deafness
__ Diabetes
__Glandular problems
__ Heart diseases
__ High blood pressure
__ Kidney disease
__ Mental Retardation
__Migraines
__ Multiple sclerosis
___ Muscular Dystrophy
___ Perceptual motor disorder
___ Seizures
___ Spinal Bifida

Comments regarding Family Health _____

_____

Child's Height _____ Weight _____.

Self Care

Nutrition:
How many consistent meals is s/he you eating/day? _____
Quantity consumed at meals ___ Low ___ Medium ___ High
Explain: _____
Quality of food eaten ___ Low ___ Medium ___ High
Explain: _____
Is there anything notable about your child's diet, appetite (gluten free, etc)? _____
Any foods avoided or does s/he only eat certain foods? _____
Does your child eat non-edible items? _____

Sleep:
How many hours of sleep does your child receive in a typical night? _____ Hours
Any problems: ___ Falling asleep __ Staying asleep
How many hours does s/he need to feel rested? _____ Hours

Exercise:
Does your child receive regular exercise? Explain type: _____ How often _____/week/month
How long does s/he exercise? _____min/hours

Disabilities:
Does your child have any physical/psychological disabilities? __ Yes __ No
Explain _____
Do you feel he/she has made an adjustment to the disability/disorder? __ Yes __ No
Does your child have any need for assistive technology in the provision of counseling services?
__ No __ Yes Explain _____

List Family history of mental illness/substance abuse:
Mother = mo; Father = fa; Sibling = s; Grandmother = gm; Grandfather = gf

Family Psychiatric History of:	Currently	In the Past	Never
ADHD			
Alcohol Abuse			
Drug Abuse			
Depression			
Anxiety			
Manic Depression (Bipolar)			
Schizophrenia			
Suicide Attempt			
Nervous Breakdown			
Panic Attacks			
Psychiatric Hospitalizations			

Do any of these illnesses significantly challenge or limit your child's ability to function at work or at home?
If yes, please provide details:

_____

_____

List Child's history of mental illness/substance abuse:

Personal (Child's) Psychiatric History of:	Currently	In the Past	Never
ADHD			
Substance Abuse			
Anxiety			
Depression			
Manic Depression (Bipolar)			
Schizophrenia			
Suicide Attempt			
Nervous Breakdown			
Panic Attacks			
Psychiatric Hospitalizations			

Any additional information that you believe would assist us in understanding your child/adolescent?

_____

_____

_____

Drug Type	Method	Age first Use	Age Last Use	Age of Onset/ of Heavy Use	Number of days used in last 30 days	Used in the last 48 Hours ?	Used as a Prescription?	Date of Last Use	Amount Used Daily	Amount Used Weekly	Drug of Choice?
Alcohol											
Heroine											
Other Opiates/ Painkillers											
Barb/Sedatives/ Hypnotics											
Other Sedatives											
Tranquilizers											
Meth/Stimulants											
Cocaine											
Crack											
Hallucinogens/ PCP											
Cannabis											
Inhalants											
Antidepressants											
Over the Counter											
Nicotine											
Caffeine											
Steroids											
Methadone/Sub-oxone											
Benzodiazepines											
Other											

Substance(s) of preference

1. _____ 3. _____
2. _____ 4. _____

Describe when and where your child typically use substances_____

_____

Describe any changes in his/her use patterns_____

_____

Describe how your child's use has affected your family or friends_____

_____

Reason(s) for use

___ Addicted ___ Build confidence ___ Escape ___ Self-medication

___ Socialization ___ Taste ___ Other (specify) _____

How do you believe your substance use affects your child's life?_____

Who or what has helped him/her in stopping or limiting your use?_____

Substance Use continued:

__ Has your child's use of alcohol or drugs interfered with his/her obligations at work?
__ Has your child's use of alcohol or drugs interfered with his/her obligations at school?
__ Has your child's use of alcohol or drugs interfered with his/her obligations at home?
__ Has your child's used alcohol or drugs while driving a car or truck?
__ Has your child used alcohol or drugs while operating machinery?
__ Has your child ever been arrested as a result of drinking or using drugs?
__ Has your child continued to use alcohol or drugs despite having problems caused by the effects of the substance?

__ Have you child ever used more alcohol or drugs in order to achieve the desired effect?
__ Has there become a markedly diminished effect with the continued use of the same amount of the substance?
__ Has your child ever needed to take a drink or use a drug in the morning in order to relieve a hangover?
__ Has your child ever used substances in larger amounts or over a longer period of time than was initially intended?
__ Has your child's attempted to cut down or control the amount of drinking or drug use without success?
__ Has your child spent a great amount of time in activities necessary to obtain the alcohol or drugs?
__ Have important social, occupational, or recreational activities been given up or reduced because of his/her use of alcohol or drugs?
__ Has your child continued to use alcohol or drugs despite knowing that physical, psychological, or legal problems are likely to occur?

Do you believe the child is suicidal at this time? __ No __ Yes

If Yes, explain_____

Do you believe the child is homicidal at this time: __ No __ Yes
If yes, explain_____

Is your child engaged in any risk taking behaviors? __No __Yes

If Yes, describe_____

_____

_____ _____
Signature of person filling out form Date

For Staff Use
Therapist's comments _____
_____
_____
_____
_____

Therapist's signature/ credentials _____Date ____/____/_____

Supervisor's comments _____
_____
_____
_____
Physical exam: __Suggested __Not suggested

Supervisor's signature/credentials *_____ Date __/____/_____
(Certifies case assignment, level of care and need for exam)
*The Medical Director's signature on the assessment form signifies his review of the information contained in this screening form.

Therapist's response to supervisor's remarks _____
_____

Therapist's signature/credentials _____ Date __/____/_____
Rev 6/18