EUNOIA
FAMILY RESOURCE CENTER, PA

REGISTRATION INFORMATION

DATE:

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	SPOUSE'S NAME		
HOME ADDRESS	CITY		STATE	ZIP	SEX: ❑ MALE ❑ FEMALE	
MARITAL STATUS ❑ MARRIED ❑ SINGLE ❑ DIVORCED ❑ SEPARATED ❑ WIDOWED	CELL PHONE		HOME/OTHER PHONE			
SOCIAL SECURITY NUMBER	WOULD YOU LIKE AN APPOINTMENT REMINDER VIA: (SELECT ONE) ❑ TEXT ❑ E-MAIL		E-MAIL ADDRESS:			
EMPLOYER OR SCHOOL NAME IF STUDENT:	HOW DID YOU FIND US?					

EMERGENCY INFORMATION

NEXT-OF-KIN (For Emergency – Other than spouse)				RELATIONSHIP
NEXT-OF-KIN ADDRESS	CITY	STATE	ZIP	NEXT-OF-KIN PHONE

RESPONSIBLE PARTY INFORMATION (If the same as patient, check "SELF" below.)

RESPONSIBLE PARTY NAME LAST	FIRST	MI		RESPONSIBLE PARTY HOME PHONE
RESPONSIBLE PARTY ADDRESS	CITY	STATE	ZIP	RESPONSIBLE PARTY SOCIAL SECURITY #
RESPONSIBLE PARTY DATE OF BIRTH	RELATIONSHIP TO RESPONSIBLE PARTY ❑ SELF ❑ SPOUSE ❑ SON ❑ DAUGHTER			

INSURANCE INFORMATION

PRIMARY INSURANCE	CARDHOLDER		DATE OF BIRTH	
GROUP NUMBER	IDENTIFICATION NUMBER			
INSURANCE ADDRESS	CITY	STATE	ZIP	PHONE
SECONDARY INSURANCE	CARDHOLDER		DATE OF BIRTH	
GROUP NUMBER	IDENTIFICATION NUMBER			
INSURANCE ADDRESS	CITY	STATE	ZIP	PHONE

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment to Eunoia Family Resource Center, PA, of any medical benefits otherwise payable to me for the services provided at Eunoia Family Resource Center, PA.

X

Patient Signature or Signature of Guardian or Parent Date

RECORDS RELEASE

I hereby authorize Eunoia Family Resource Center, PA, to release my records to my insurance company for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payor.

X

Patient Signature or Signature of Guardian or Parent Date

EUNOIA
FAMILY RESOURCE CENTER, PA

1420 N. State Street
Fairmont, MN 56031
Phone: (507) 235-6070
Fax: (855) 847-9876

Consent for Treatment of a Minor

I,_____, the parent/legal guardian of the minor, _____, give my permission for this minor to receive treatment, which may include individual therapy, family therapy, assessments/testing and psychiatric medication management, from Eunoia Family Resource Center.

I am the legal guardian of this minor, and there are no court orders in effect that would prohibit me from consenting to the treatment of this minor. If at any point my status as parent/legal guardian changes, I will provide Eunoia Family Resource Center with appropriate documentation. By signing this document, I acknowledge that any releases of information, except for those which would apply to legal situations or are court-related, would only require one legal guardian's signature. I understand that the patient's therapist cannot make recommendations for court proceedings concerning custody or parenting issues or testify in court concerning opinions on issues involved in such litigation. By signing this document, I agree not to call the patient's therapist as a witness in any such litigation.

If I wish to revoke this consent, I will provide appropriate notice to Eunoia Family Resource Center.

My signature below means that I understand and agree with all of the points above.

_____ _____

Signature of Parent/Guardian Date

Eunoia Family Resource Center, PA
Financial Policy

Thank you for choosing us as your health care provider. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment. All clients must complete our Registration Form before seeing a psychotherapist.

ALL CO-PAYS ARE DUE AT THE TIME OF YOUR SESSION.
WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD/DISCOVER.

Regarding Insurance:
We may accept assignment of insurance benefits. The balance is your responsibility, whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a 3rd party to that contract. In the event that we do accept assignment of benefits and your insurance has not paid your account in full within 60 days, the balance will be automatically transferred to your responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance. You will be financially responsible for any services that are deemed not medically necessary, non-covered or investigational by your health insurance provider. Contact your employer or insurer if you have questions.

All co-pays are due at the time of your session when you use an insurance plan for which your clinician is a participating provider. In the event that your insurance coverage changes, it is your responsibility to notify us. If your new plan is one for which we are not participating providers, you are responsible for your account. Any follow-up or reporting to 3rd parties that become necessary due to unpaid balances on your account shall not be considered breach of confidentiality.

Adult Patients:
Adult patients are responsible for full payment of any co-pays at the time of service.

Minor Patients:
Parents or guardians accompanying minors are responsible for payment of co-pays at the time of service. If a minor is accompanied by an adult other than a parent or guardian, payment is still expected at the time of service. For unaccompanied minors, charges may be preauthorized to an approved credit plan, VISA/Mastercard/Discover, or paid by cash or check at the time of service.

Missed Appointments:
For ALL appointments, unless cancelled with at least 24 hours' notice, a charge of $75 may be applied to your account. This charge is normally not payable by your insurance and will be billed as your responsibility. Please help us serve you better by keeping scheduled appointments. Exceptions: late cancellations due to illness or bad weather causing school closures will be honored.

Service/Finance Charges, Court Fees:
- A monthly finance charge of 1.5% is charged for balances exceeding 30 days.
- Accounts exceeding 90 days may be reported to a collection agency.
- There is a $25.00 service charge for returned checks.
- Fees for court are $500/hour for all time incurred on the case, including but are not limited to prep time, office staff time, travel, and in-court time (regardless of whether on stand or not). These fees are not covered by insurance.

Nondiscrimination:
No person may be denied services because of the person's sex, race, religion, national origin, ancestry, creed, pregnancy, marital or parental status, sexual orientation or physical, mental, emotional or learning disability.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your health information and provide you with a description of our privacy practices. This notice will also describe your rights and certain obligations we have regarding the use and disclosure of your health information.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health information is personal. We are committed to protecting your health information. We create a record of the care and services you receive at this office. We need this record to provide you with quality care and comply with certain legal requirements. This notice applies to all of the records of your care generated by this office, whether made by your clinician or one of the office's employees.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

The following describes the different ways that your protected health information (PHI) may be used or disclosed by this office. "PHI" refers to information in your health record that could identify you. For clarification, we have included some examples. Not every possible use of disclosure is specifically mentioned. However, all of the ways we are committed to use and disclose your PHI will fit within one of these general categories:

- For Treatment: "Treatment" is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another mental health clinician.
- For Payment: "Payment" is when we obtain reimbursement for your health care. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. We may also tell your health plan insurer about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover or continue to cover your treatment.
- For Healthcare Operations: "Healthcare Operations" are activities that relate to the performance and operation of our practice. Examples of healthcare operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. We may use and disclose health information to provide you with appointment information. This may be done with voice mail, text messages, e-mails, postcards, or other mailings.
- Use: "Use" applies only to activities within our office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- Disclosure: "Disclosure" means activities outside of our office, such as releasing, transferring, or providing access to information about you to other parties.

II. Use and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or healthcare operations when your appropriate authorization is obtained. An authorization is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment, or healthcare operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. Psychotherapy notes are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, the law provides the insurer the right to contest the claim under the policy.

III. Use and Disclosures with Neither Consent Nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If we have reasonable cause to suspect child abuse or neglect, we must report this suspicion to the appropriate authorities as required by law.
- Vulnerable Adult Abuse: If we have reasonable cause to suspect a vulnerable adult has been criminally abused, we must report this suspicion to the appropriate authorities as required by law.
- Health Oversight Activities: If we receive a subpoena or other lawful request from the Department of Health or the appropriate licensing board, we must disclose the relevant PHI pursuant to that subpoena or lawful request.
- Judicial and Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may use your PHI to defend the office or to respond to a court order.
- Law Enforcement: We may release PHI about you if required by law when asked to do so by a law enforcement official.
- Serious Threat to Health or Safety: If you communicate to us a threat of physical violence against a reasonably identifiable third person and you have the apparent intent and ability to carry out that threat in the foreseeable future, we may disclose relevant PHI and take the reasonable steps permitted by law to prevent the threatened harm from occurring. If we believe that there is an imminent risk that you will inflict serious physical harm on yourself, we may disclose information in order to protect you.
- Worker's Compensation: We may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Clinician's Duties

You have the following rights regarding the PHI that this office maintains about you:

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen at our office. On your request, we will send your bills to another address.) To request confidential communications, you must complete our request form in writing and submit it to the privacy officer. We will accommodate all reasonable requests.
- Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. To inspect and/or obtain a copy of your PHI, you must complete our request form and submit it to the privacy officer. If you request copies, we will charge you $0.10 per page. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. To request an amendment, you must submit it in writing to the privacy officer. In addition, you must provide a reason that supports your request. We may deny your request. On your request, we will discuss with you the details of the amendment process.

- Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process. To request this accounting on disclosures, you must complete a request form and submit it in writing to the privacy officer. Your request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003.
- Right to a Paper Copy: You have the right to obtain a paper copy of this notice from us upon request.

Clinician's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact the privacy officer at Eunoia Family Resource Center listed below.

If you believe that your privacy rights have been violated and wish to file a complaint with us/our office, you may send your written complaint to the privacy officer at Eunoia Family Resource Center. All complaints must be submitted in writing to:

Privacy Officer:
Ramie M. Vetter, Psy.D., LP
Eunoia Family Resource Center, PA
1420 N. State Street, Fairmont, MN 56031
(507) 235-6070

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you or penalize you in any way for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. If we revise our policies and procedures, we will post a copy of any revised notice in this office.

Other uses and disclosures of your PHI not covered by this notice of privacy practices will be made only with your written authorization. If you provide us such an authorization in writing to use or disclose PHI about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose PHI about you for the reasons covered by your written authorization. Be aware that we are unable to take back any disclosures we have already made with your permission, and we are required to retain our records of care that we provide to you.

In case of an emergency, please call 911 or the South Central Crisis Center at 877-399-3040. Outside of our normal business hours, you may leave a message on our voicemail or call the South Central Crisis Center.

ACKNOWLEDGMENT

By signing below, I acknowledge that I have received a copy of this office's notice of privacy practices.

_____ _____

Patient/Parent/Guardian Signature Date

ACKNOWLEDGMENT

By signing below, I acknowledge that I have received a copy of this office's financial policy.

_____ _____

Patient/Parent/Guardian Signature Date

ACKNOWLEDGMENT

By signing below, I acknowledge that I

□ Do

□ Do Not

intend to give permission for Eunoia Family Resource Center to contact my primary care physician. This will require a separate release of information.

_____ _____

Name of Primary Care Physician

_____

Address of Primary Care Physician

_____ _____

Patient/Parent/Guardian Signature Date

EUNOIA
FAMILY RESOURCE CENTER, PA

1420 N. State Street
Fairmont, MN 56031
Phone: (507) 235-6070
Fax: (855) 847-9876

Authorization for Release of Information

I,_____ _____

Name of Client | Date of Birth

_____ _____

Address | Social Security Number - Optional

_____ _____,

City, State, Zip | Phone Number

authorize Eunoia Family Resource Center, 1420 N. State Street, Fairmont, MN 56031, to disclose to and receive information from:

_____

Name of Individual and Organization Name, if Applicable

_____

Street Address | City, State, Zip

_____ _____

Phone Number | Fax Number

The following information that relates to my treatment: _____Any of the Following Information

_____Summaries (Case, Discharge, etc.) _____Treatment Plans and Reviews _____Emergency Contact
_____Chemical Health Information _____Scheduling _____Medical History and Physical
_____Diagnostic Assessment _____Questionnaires/Screeners _____Neuro-/Psychological Testing
_____Legal _____Notes (Case, Progress, Group, etc.) _____UA/Labs
_____Medications/Dosage _____Consults _____Billing

Purpose for Disclosure: _____Coordination and/or Continuation of Care _____Other: _____

_____

Patient Restrictions on Methods for Disclosure:

I understand that communication of the items can occur: _____Any of the Following Information

_____Verbally _____In-person Conference _____Written
_____Mailed or Faxed Medical Record/Correspondence _____E-Mailed Records/Correspondence

I understand that:

*My health information is protected by federal regulation (Alcohol and Drug Abuse Patient Records, 42 CFR Part 2: and/or HIPAA 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances described in Eunoia Family Resource Center, PA's Privacy Notice. I understand that I have a right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws.

*I can revoke this authorization at any time except to the extent that action has been taken in reliance on it. Eunoia Family Resource Center, PA's Privacy Notice outlines the procedure for revocation. This authorization will expire in one year from the date I sign or unless I request an earlier expiration in writing.

This Authorization for Release of Information will remain in effect until: _____.

*For disclosures other than for treatment, payment and healthcare operations purposes, treatment may not be conditioned on my agreement to sign and authorize (unless I am receiving care solely to create protected health information for disclosure to a third party) (45 CFR & 164.508 (b)(4)(III).

*Communications resulting from this authorization will reveal that I receive services at Eunoia Family Resource Center, PA.

*Federal confidentiality regulations (at 42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient records. However, HIPAA requires Eunoia Family Resource Center, PA, to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA rules.

*This authorization may be used by Eunoia Family Resource Center, PA, owned or managed programs upon transfer of my care to them.

_____ _____

Patient or Guardian Signature | Date

Minnesota Department of **Human Services**

DHS-5704A-ENG 1-14

Children's Mental Health

Child/Adolescent Diagnostic Assessment

(TO BE COMPLETED BY PARENT/CAREGIVER)

PART 1 – Please provide the following information in preparation for the interview with your mental health clinician.

DATE

CHILD NAME (FIRST, MI, LAST)	CLIENT NUMBER	REFERRAL SOURCE

REASON FOR REFERRAL

NAME OF INDIVIDUAL COMPLETING FORM	RELATIONSHIP TO CHILD

{PROVIDER: Enter the phone number your agency uses to provide help interpreting.}

Attention. If you need free help interpreting this document, call the above number.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB3-0001 (3-13)

ADA1 (12-12)

This information is available in accessible formats for individuals with disabilities by calling 651-431-2321, toll-free 800-627-3529, or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.

Living situation

Parent's Home	Residential Care/Treatment Facility**		Other**	
☐ RENT	☐ HOSPITAL	☐ TEMPORARY HOUSING	☐ FRIEND'S HOME	☐ RELATIVE/GUARDIAN'S HOME
☐ OWN	☐ RESIDENTIAL CARE	☐ NURSING HOME	☐ HOMELESS	☐ FOSTER HOME

**IDENTIFY PERSON'S NAME OR FACILITY

Primary Household

Household member name	Relationship to child	Age	Occupation/School	Highest level of education	Quality of relationship

STREET ADDRESS (If different from child's address listed on Demographic Information form.)

Does the client live in more than one household?

☐ **NO** If no, skip to "Additional Family Members" ☐ **YES** If yes, complete the secondary household information below.

Secondary Household

Household member name	Relationship to child	Age	Occupation/School	Highest level of education	Quality of relationship

STREET ADDRESS (If different from child's address listed on Demographic Information form.)

Family members who live in both households

☐ ONLY CHILD

☐ CHILD and (list):

Additional family members

☐ NO, parents or sibling other than those listed in primary or secondary households

☐ YES, list family members:

Custody and parenting plan

☐ LIVES WITH BOTH PARENTS (biological or adoptive) in same household

☐ SINGLE PARENT

☐ SHARED CUSTODY – parents in different households

☐ OTHER (describe):

Developmental issues

Have you ever had concerns about the following issues with this child?

Pregnancy	Yes	No	Unknown
Had bleeding during first three (3) months	☐	☐	☐
Had bleeding during second three (3) months	☐	☐	☐
Had bleeding during last three (3) months	☐	☐	☐
Had toxemia	☐	☐	☐
Had to take medications Specify any medication:	☐	☐	☐
Got injured or hurt	☐	☐	☐
Gained less than 15 lbs. (7 kgs.) Specify:	☐	☐	☐
Took narcotic drugs	☐	☐	☐
Drank alcohol	☐	☐	☐
Had an infection	☐	☐	☐
Smoked during pregnancy	☐	☐	☐
Length of pregnancy: months	☐	☐	☐
Other pregnancy problems/illnesses Specify:	☐	☐	☐

Birth/Early Infancy	Yes	No	Unknown
Born prematurely	☐	☐	☐
Born with cord around neck	☐	☐	☐
Injured during birth	☐	☐	☐
Had trouble breathing	☐	☐	☐
Turned blue (cyanosis)	☐	☐	☐
Was a twin or triplet	☐	☐	☐
Had an infection	☐	☐	☐
Had seizures (fits, convulsions)	☐	☐	☐
Needed oxygen	☐	☐	☐
Was very jittery	☐	☐	☐

Childhood Health Issues	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Seizures (convulsions) or spells	☐	☐	☐		☐
High fevers (over 103° F. or 39° C.)	☐	☐	☐		☐
Head injury	☐	☐	☐		☐
Asthma	☐	☐	☐		☐
Trouble with hearing	☐	☐	☐		☐
Trouble with vision	☐	☐	☐		☐
Lead poisoning	☐	☐	☐		☐
Other poisoning or overdose	☐	☐	☐		☐
Other serious illness	☐	☐	☐		☐
Other hospitalizations	☐	☐	☐		☐

Functioning	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Poor appetite	☐	☐	☐		☐
Constipation	☐	☐	☐		☐
Stomach aches	☐	☐	☐		☐
Trouble falling asleep	☐	☐	☐		☐
Trouble staying asleep	☐	☐	☐		☐
Overactivity	☐	☐	☐		☐
Head banging	☐	☐	☐		☐
Rocking in bed	☐	☐	☐		☐
Temper tantrums	☐	☐	☐		☐
Self-destructive behavior	☐	☐	☐		☐
Difficulty in being comforted or consoled	☐	☐	☐		☐
Stiffness or rigidity	☐	☐	☐		☐
Looseness or floppiness	☐	☐	☐		☐
Crying often and easily	☐	☐	☐		☐
Shyness with strangers	☐	☐	☐		☐
Irritability	☐	☐	☐		☐
Extreme reaction to noise or sudden movement	☐	☐	☐		☐
Attention problems	**Yes**	**No**	**Unknown**	**If yes, age first noted**	**If yes, still occurring?**
Can concentrate for only a short time unless things are very interesting	☐	☐	☐		☐
Understand the main ideas of things but misses important details	☐	☐	☐		☐
Does work or performs many tasks carelessly without thinking	☐	☐	☐		☐
Learns a new skill well one day and then can't seem to do it a few days later	☐	☐	☐		☐
Receives very unpredictable (inconsistent) grades or test scores in school	☐	☐	☐		☐
Can work well only on things he/she really enjoys doing or thinking about	☐	☐	☐		☐
Often doesn't notice when he/she makes mistakes	☐	☐	☐		☐
Seems not to realize when he/she is disturbing someone	☐	☐	☐		☐
Doesn't do much better after punishment or correction	☐	☐	☐		☐
Makes comments about or is distracted by background noises or unimportant things	☐	☐	☐		☐
Seems to want things right away and/or is hard to satisfy	☐	☐	☐		☐
Annoys or bothers other children	☐	☐	☐		☐
Behavior is variable and hard to predict	☐	☐	☐		☐
Is a troublemaker; bullies others	☐	☐	☐		☐

Behaviors	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Has bad dreams	☐	☐	☐		☐
Is often very quiet or withdrawn	☐	☐	☐		☐
Is often "down" on himself/herself	☐	☐	☐		☐
Is often tired	☐	☐	☐		☐
Speaks unclearly, stutters, or stammers	☐	☐	☐		☐
Wets bed or pants often	☐	☐	☐		☐
Soils underwear or has accidents with bowel movements	☐	☐	☐		☐
Is often too neat or orderly	☐	☐	☐		☐
Is often too concerned about cleanliness	☐	☐	☐		☐
Often plays with matches	☐	☐	☐		☐
Destroys objects at home	☐	☐	☐		☐
Destroys objects away from home	☐	☐	☐		☐
Is fearless	☐	☐	☐		☐
Is cruel to animals	☐	☐	☐		☐
Is not liked by other children	☐	☐	☐		☐
Feels ill on school mornings	☐	☐	☐		☐
Has eating problems (either overeats or undereats)	☐	☐	☐		☐
Is preoccupied with food or diet	☐	☐	☐		☐
Is part of a clique or gang that causes trouble	☐	☐	☐		☐
Other behaviors not noted above	☐	☐	☐		☐
Have you ever had concerns about your child's early development (i.e. walking, talking, learning)?	☐	☐	☐		☐
Have you ever had concerns about your child's sexual development or behaviors?	☐	☐	☐		☐

IF THERE ARE INDICATIONS OF ISSUES, PLEASE EXPLAIN

Child's school functioning

Education classification

Does your child have an IEP for special education services? ☐ YES ☐ NO

If no, has your child ever been tested and determined not to need services? ☐ YES ☐ NO

Regular education classroom, no special services ☐ YES ☐ NO

If no, check all that apply below.

- ☐ Early Childhood Spec. Ed./Developmental Delay
- ☐ Special Learning Disability
- ☐ Hearing Impaired
- ☐ Visually Impaired
- ☐ Speech or Language Impaired
- ☐ Physically Impaired
- ☐ Emotional/Behavioral Disorder
- ☐ Developmental/Cognitive Disability
- ☐ Special learning disability
- ☐ Autism Spectrum Disorder
- ☐ Traumatic brain injury
- ☐ Other health impaired
- ☐ Unsure
- ☐ Current 504 plan
- ☐ Other:

COMMENTS ON EDUCATIONAL CLASSIFICATION

Child's legal history

Does your child have a history of legal charges? ☐ NO ☐ YES

IF YES, DESCRIBE CHARGES

Is the child currently on probation? ☐ NO ☐ YES

Has the child ever been on probation? ☐ NO ☐ YES

Has the child ever been court-ordered into chemical health or mental health treatment? ☐ NO ☐ YES

Has the child ever had involvement with Child Protective Services (CPS)? ☐ NO ☐ YES

IF YES, DESCRIBE

NAME OF CPS CASEWORKER(S) ASSIGNED TO FAMILY (IF APPLICABLE)

☐ NONE REPORTED

NAME OF GUARDIAN AD LITEM (GAL) OR COURT APPOINTED SPECIAL ADVOCATE (CASA) ASSIGNED TO FAMILY

☐ NONE REPORTED

Child's trauma history

Has your child experienced or witnessed any of the following? (check all that apply)

- ☐ Car accident
- ☐ Other accident
- ☐ Physical illness
- ☐ Physical abuse
- ☐ Domestic violence/abuse
- ☐ Emotional abuse
- ☐ Physical neglect
- ☐ Sexual assault/molestation
- ☐ Community violence
- ☐ Fire
- ☐ Natural disasters
- ☐ Other:
- ☐ None of the above

Child's mental health treatment history

Previous mental health treatment ☐ NO ☐ YES If yes, please list reason for treatment, and dates:

Reason	Dates

Currently on any medication(s)? ☐ NO ☐ YES

IF YES, PLEASE LIST AND BRING MEDICATIONS TO NEXT APPOINTMENT

PRIMARY CARE PHYSICIAN			PHONE NUMBER
ADDRESS	CITY	STATE	ZIP CODE
OTHER PRESCRIBING PHYSICIAN(S)			PHONE NUMBER
ADDRESS	CITY	STATE	ZIP CODE

Child's alcohol and drug history

Do you have any concerns about your child's use of alcohol or drugs? ☐ NO ☐ YES

Do you have any other issues or concerns about your child you would like to have addressed? ☐ NO ☐ YES

COMMENTS

Family Environment/Relationships

Please indicate below the best descriptions of parent-child relationships.

Parent-Child (Client) Relationship(s)	**P = Primary household**		**S = Secondary household**	**B = Both**	
Parent-child conflict	NONE – MILD	MODERATE	SEVERE		
Issues with supervision and monitoring of child	ALWAYS	USUALLY	INCONSISTENTLY	RARELY	
Cooperation between parents regarding child-rearing	ALWAYS	USUALLY	INCONSISTENTLY	RARELY	NOT PERTINENT
Parent positive activities with child	FREQUENT	OCCASIONALLY	INFREQUENT		
Parent satisfaction with relationship	SATISFIED	NEUTRAL	DISSATISFIED		
Child satisfaction with relationship	SATISFIED	NEUTRAL	DISSATISFIED		
COMMENT ON PARENT-CHILD RELATIONSHIPS (describe further if needed)					

Please indicate below the best descriptions of sibling-child relationships.

Sibling-Child (Client) Relationship(s) ☐ NO SIBLINGS	**P = Primary household**	**S = Secondary household**	**B = Both**
Child-sibling conflict	NONE – MILD	MODERATE	SEVERE
Sibling(s) positive activities with child	FREQUENT	OCCASIONAL	INFREQUENT
Sibling(s) satisfaction with relationship	SATISFIED	NEUTRAL	DISSATISFIED
Child satisfaction with relationship	SATISFIED	NEUTRAL	DISSATISFIED
COMMENT ON SIBLING-CHILD RELATIONSHIPS (describe further if needed)			

Please indicate below the best descriptions of parent marital or couple relationships.

Parent Marital or Couple Relationship(s) ☐ NOT APPLICABLE	**P = Primary household**	**S = Secondary household**	**B = Both**
Marital or couples conflict	NONE – MILD	MODERATE	SEVERE
Marital or couples satisfaction	SATISFIED	NEUTRAL	DISSATISFIED
COMMENT ON PARENT MARITAL OR COUPLES RELATIONSHIPS (describe further if needed)			

Other Family Concerns			If yes, indicate:		
	No	Yes	Parent	Sibling	Other
Family member health problems	☐	☐			
Family member disability	☐	☐			
Family member legal issues	☐	☐			
Family financial concerns	☐	☐			
Family member alcohol abuse	☐	☐			
Family member substance abuse	☐	☐			
Family member anxiety	☐	☐			
Family member depression	☐	☐			
Family member ADHD	☐	☐			
Family member mania	☐	☐			
Family member schizophrenia/other psychosis	☐	☐			
Significant family stressors (moves, deaths, divorce, loss of employment)	☐	☐			

COMMENT ON OTHER FAMILY CONCERNS AND INFORMATION RELATING TO FINANCIAL STATUS (Specify problems that impact child's needs.)

Kiddie-CAGE

1. Have you used more than one **chemical** at the same time in order to get high?	☐ Yes ☐ No
2. Do you **avoid** family activities so you can use?	☐ Yes ☐ No
3. Do you have a **group** of friends who use?	☐ Yes ☐ No
4. Do you use to improve your **emotions** such as when you feel sad or depressed?	☐ Yes ☐ No

*When paraphrasing, it is important to keep the meaning of the bolded text intact.
Scoring: Each question is scored 1 point.
A score of 2 or more indicates the likelihood of a substance use disorder.

Ken Winters, Ph.D., Department of Psychiatry, University of Minnesota, Unpublished, 2001.

Patient Health Questionnaire for Adolescents (PHQ-A)

Name:_____ **Date:**_____

How often have you been bothered by each of the following symptoms during the past <u>two weeks</u>? For each symptom put an "X" in the box beneath the answer that best describes have you have been feeling.

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling down, depressed, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself, or that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like schoolwork, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				

	Yes	No
In the **<u>past year</u>**, have you felt depressed or sad most days, even if you felt okay sometimes?		

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?				

	Yes	No
Has there been a time in the **<u>past month</u>** when you have had serious thoughts about ending your life?		

	Yes	No
Have you **<u>EVER</u>** in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?		

****If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room, or call 911.**

Strengths and Difficulties Questionnaire

S 11-17

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain . Please give your answers on the basis of how things have been for you over the last six months.

Your name..... Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	☐	☐	☐
I am restless, I cannot stay still for long	☐	☐	☐
I get a lot of headaches, stomach-aches or sickness	☐	☐	☐
I usually share with others, for example CD's, games, food	☐	☐	☐
I get very angry and often lose my temper	☐	☐	☐
I would rather be alone than with people of my age	☐	☐	☐
I usually do as I am told	☐	☐	☐
I worry a lot	☐	☐	☐
I am helpful if someone is hurt, upset or feeling ill	☐	☐	☐
I am constantly fidgeting or squirming	☐	☐	☐
I have one good friend or more	☐	☐	☐
I fight a lot. I can make other people do what I want	☐	☐	☐
I am often unhappy, depressed or tearful	☐	☐	☐
Other people my age generally like me	☐	☐	☐
I am easily distracted, I find it difficult to concentrate	☐	☐	☐
I am nervous in new situations. I easily lose confidence	☐	☐	☐
I am kind to younger children	☐	☐	☐
I am often accused of lying or cheating	☐	☐	☐
Other children or young people pick on me or bully me	☐	☐	☐
I often offer to help others (parents, teachers, children)	☐	☐	☐
I think before I do things	☐	☐	☐
I take things that are not mine from home, school or elsewhere	☐	☐	☐
I get along better with adults than with people my own age	☐	☐	☐
I have many fears, I am easily scared	☐	☐	☐
I finish the work I'm doing. My attention is good	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that you have difficulties in any of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes-minor difficulties	Yes-definite difficulties	Yes-severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress you?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties make it harder for those around you (family, friends, teachers, etc.)?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

Your Signature ..... Today's Date .....

Thank you very much for your help

Strengths and Difficulties Questionnaire

P 11-17

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior over the last six months.

Your child's name ..... Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other youth, for example CD's, games, food	☐	☐	☐
Often loses temper	☐	☐	☐
Would rather be alone than with other youth	☐	☐	☐
Generally well behaved, usually does what adults request	☐	☐	☐
Many worries or often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other youth or bullies them	☐	☐	☐
Often unhappy, depressed or tearful	☐	☐	☐
Generally liked by other youth	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other youth	☐	☐	☐
Often offers to help others (parents, teachers, children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets along better with adults than with other youth	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Good attention span, sees chores or homework through to the end	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress your child?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

Signature ..... Date .....

Mother/Father/Other (please specify:)

Thank you very much for your help