

Insurance Verification - Clinician Name _____

| | | | |
|--|-------------------------------------|-------|---------|
| Name of Patient | Name: | DOB: | Gender: |
| Street Address | Street: | Apt: | |
| | City | State | Zip |
| Phone | Ok to Text? Y/N OK to Voicemail Y/N | | |
| Email | OK appointment reminders Y/N | | |
| Emergency Contact | Relationship | Phone | |
| Complete below if under 19 years old or under 26 using parents insurance | | | |
| Guardian/Parent | Name: | DOB: | |
| | Street: | Apt: | |
| | City | State | Zip |
| | Phone | | |

| | |
|-------------------------|-------------------------------------|
| Insurance | |
| Subscriber Name | Male / Female |
| Subscriber DOB | Relationship: Self / Spouse / Child |
| ID Number | Group # |
| Employer (or ACA) | |
| Benefit Phone # | |
| Second Insurance | |
| Subscriber Name | Male / Female |
| Subscriber DOB | Relationship: Self / Spouse / Child |
| ID Number | Group # |
| Employer (or ACA) | |
| Benefit Phone # | |

Please call your insurance ahead of time and get the following information.

What is my Copay/Coinsurance? _____

How much Deductible is left? _____

Are hour sessions (CPT 90837) covered? Y / N _____

Are Family sessions (CPT 90847) covered? Y / N _____

Waiver for Private Pay Clients (Skip if using insurance)

At times patients with insurance coverage prefer to pay privately for confidentiality reasons. Using your insurance requires passing along information regarding diagnosis necessary for reimbursement (see Confidentiality Statement and HIPAA policies). This information is discoverable by underwriters of life, long-term care, and medical insurance policies and may impact future premiums or coverage.

Also It is common for insurance not to pay for marriage/couples/sex therapy. It is unethical and a breach of contract with your insurance company to bill “as family therapy” in order to get paid. If your insurance does not cover either the diagnosis (Z codes), or Marriage Counseling – a payment at time of service discount rate listed below is the alternative.

The usual rate is \$225.00 for intakes, \$130.00 individual and \$150.00 for couples; however, payment at time of service permits a discounted rate of:

- \$95.00 for intake appointment (60 minutes).
- \$75.00 for 45 minute session (individual)
- \$85.00 for 60 minutes session (individual)
- \$95.00 for family/couples (60 minutes).

_____ (initial) I understand that I do not have mental health/marriage counseling benefits as part of my insurance policy or I do not meet the criteria for medical necessity and choose to continue through private pay OR...

_____ (initial) I am choosing to pay privately and will not submit to my insurance company for reimbursement. Should I desire to use my insurance in the future. I understand that I must revoke this waiver in writing AND only submit to insurance those sessions that have occurred AFTER the date of my written notification.

Client / Guardian Signature

Date

Informed Consent for Therapy

Therapy will work on the goals that you bring. When working as a family/couple, the goals that support the relationships will be the focus of counseling. Generally this works well, but sometimes it can be challenging emotionally and take some additional time throughout your week. Sometimes looking at problems to make changes is uncomfortable, please let me know if this is happening so I can help. Copies of the treatment plan can be requested at any time as part of the medical record for the patient to review. You have the right to refuse therapy or terminate at any time.

I won't do tests or assessments without your knowledge and agreement. Your records are kept secure according to state and federal regulations. We use an electronic health record through a business agreement that is HIPAA compliant. If you have questions on this please feel free to ask. Your specific therapist and their supervisor/administrator have access to your records. Regarding couples counseling: Intakes will be stored individually. Couples counseling will be billed as "family" sessions, the identified patient for insurance billing purposes will be discussed at your intake session along with confidentiality of the file.

Unless you are using Medicaid, your physician will not be notified of your treatment unless you or they specifically request this. If you are using Medicaid and do not want your physician contacted, let your therapist know.

I cannot provide crisis counseling. I return calls during office hours (described on my voicemail). If you have a medical emergency, please contact 911 emergency services. Otherwise – please use family and friends for support until an "urgent" appointment can be scheduled (within 24 hours). I do provide some limited phone contact through scheduled arrangements, this is not covered by insurance and will be billed according to my private pay rate. An on-call therapist is available to return calls within 30 minutes if requested in the voicemail message..

I do not use social media to connect with, friend, message or otherwise communicate with patients. Posts / messages that this therapist believes may compromise your confidentiality will be deleted. Leaving "reviews" (positive or negative) online limits your confidentiality and cannot be addressed online. Please call the Owner at 402-325-0117 x1 with any positive or negative feedback.

As the work we do requires clear thinking and can stir strong emotions, you cannot come under the influence of drugs or alcohol. Weapons are not allowed in the office. If your therapist suspects this, your appointment will be rescheduled.

Non-therapeutic services such as letter writing, appearing in court, being deposed, phone consultations, etc. are subject to additional fees as defined by your therapist. If you have any questions, please ask in advance. Missed appointments with less than 24 hours notice are subject to a \$50.00 late cancellation / no show fee charged to the card on file. Repeated (generally more than three) missed appointments may be subject to scheduling limitations.

Payments may be collected at the time of service. Any amounts not covered by insurance either due to deductibles; co-insurance; denied services, diagnoses, or dates of service will be the patient responsibility. Amounts over 90 days past due may be automatically collected by your therapist using the credit card on file Unpaid balances over 120 days will be submitted to collections. **I authorize and request AdultSpan Counseling to charge my credit card on file, as indicated above. This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60 day notification to AdultSpan PC in writing: 1001 S 70th St. #225 Lincoln 68510. Charges on your credit card statement may appear as ASC, Adultspan PC or Adultspan Counseling.**

Name and date

Confidentiality of your Information

Confidentiality of your Information

What is said in therapy needs to be confidential in order for therapy to work. Confidentiality means that your therapist will protect verbal, written/electronic information (i.e., your file) according to state and federal guidelines. You may identify specific persons that you do NOT want to be able to obtain your records.

There are some limits to confidentiality. If you feel that you may harm yourself or others, your therapist will use the least information to the fewest people possible to reasonably ensure safety. Your therapist is required by law to report suspected abuse or neglect of a child or vulnerable adult to the authorities. At times your therapist will consult with other therapists about your treatment without identifying you.

Family or couples therapy is only as confidential as the other people in the room. Please respect each other's confidentiality. While your therapist would encourage you to use your support system (friends and family), please limit what you share about therapy. There will be only one "family" file. Your therapist will discuss who is the identified patient for the file/billing. At times it may make sense to see members of the family individually and as a family. The pro/cons of this will be discussed as well as how the confidentiality for individual sessions will be handled.

Parents are asked to respect that confidentiality is important for children too. Your therapist will let you know if your minor child is in imminent harm. Just because your child may discuss risky behaviors does not mean they are in imminent harm. If you would like to clarify what you'd like to be told about, please talk to your therapist.

Your insurance requires date, diagnosis and the service in order to pay. They may rarely also request your file to ensure the services were "medically necessary." If you're concerned about this you may pay for your services yourself; however, you cannot submit it to insurance for reimbursement. Payment information may be sent via the credit card system to the email on file if you request a receipt.

If you contact your therapist through an insecure means (e.g., email or text) you agree that your therapist may respond with the requested information with the same communication channel. However, your therapist may require you to schedule a session or phone contact to discuss complex or sensitive information.

Court or legal requests for records will start with an attempt to get a release from all persons attending the sessions. If it is denied, this therapist will work to keep your information protected; however, ultimately may end up having to testify. This unlikely, and if you're concerned about this talk with your therapist about how this will be handled.

By signing below I agree I understand my rights and limits for confidentiality. I have been offered and received, if requested, a copy of the HIPAA policy for AdultSpan Counseling. It is also available on the website.

Name and date

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _____ Age: _____ Sex: Male Female Date: _____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

| | | None Not at all | Slight Rare, less than a day or two | Mild Several days | Moderate More than half the days | Severe Nearly every day | Highest Domain Score (clinician) |
|--|-----|------------------------------|--|-----------------------------|---|----------------------------------|---|
| During the past TWO (2) WEEKS , how much (or how often) have you... | | | | | | | |
| I. | 1. | 0 | 1 | 2 | 3 | 4 | |
| | 2. | 0 | 1 | 2 | 3 | 4 | |
| II. | 3. | 0 | 1 | 2 | 3 | 4 | |
| III. | 4. | 0 | 1 | 2 | 3 | 4 | |
| IV. | 5. | 0 | 1 | 2 | 3 | 4 | |
| | 6. | 0 | 1 | 2 | 3 | 4 | |
| V. & | 7. | 0 | 1 | 2 | 3 | 4 | |
| VI. | 8. | 0 | 1 | 2 | 3 | 4 | |
| VII. | 9. | 0 | 1 | 2 | 3 | 4 | |
| | 10. | 0 | 1 | 2 | 3 | 4 | |
| VIII. | 11. | 0 | 1 | 2 | 3 | 4 | |
| | 12. | 0 | 1 | 2 | 3 | 4 | |
| | 13. | 0 | 1 | 2 | 3 | 4 | |
| IX. | 14. | 0 | 1 | 2 | 3 | 4 | |
| | 15. | 0 | 1 | 2 | 3 | 4 | |
| X. | 16. | 0 | 1 | 2 | 3 | 4 | |
| | 17. | 0 | 1 | 2 | 3 | 4 | |
| | 18. | 0 | 1 | 2 | 3 | 4 | |
| | 19. | 0 | 1 | 2 | 3 | 4 | |
| In the past TWO (2) WEEKS , have you... | | | | | | | |
| XI. | 20. | <input type="checkbox"/> Yes | | <input type="checkbox"/> No | | | |
| | 21. | <input type="checkbox"/> Yes | | <input type="checkbox"/> No | | | |
| | 22. | <input type="checkbox"/> Yes | | <input type="checkbox"/> No | | | |
| | 23. | <input type="checkbox"/> Yes | | <input type="checkbox"/> No | | | |
| XII. | 24. | <input type="checkbox"/> Yes | | <input type="checkbox"/> No | | | |
| | 25. | <input type="checkbox"/> Yes | | <input type="checkbox"/> No | | | |

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LEVEL 2—Depression—Child Age 11–17*
 *PROMIS Emotional Distress—Depression—Pediatric Item Bank

Name: _____ Age: _____ Sex: Male Female Date: _____

Instructions to the child: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you have been bothered by “having little interest or pleasure in doing things” and/or “feeling down, depressed, or hopeless” at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often you have been bothered by a list of symptoms **during the past 7 days**. Please respond to each item by marking (✓ or x) one box per row.

| In the past SEVEN (7) DAYS... | | | | | | Clinician Use |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|---------------|
| | Never | Almost Never | Sometimes | Often | Almost Always | Item Score |
| 1. I could not stop feeling sad. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 2. I felt alone. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 3. I felt everything in my life went wrong. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 4. I felt like I couldn't do anything right. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 5. I felt lonely. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 6. I felt sad. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 7. I felt unhappy. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 8. I thought that my life was bad. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 9. Being sad made it hard for me to do things with my friends. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 10. I didn't care about anything. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 11. I felt stressed. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 12. I felt too sad to eat. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 13. I wanted to be by myself. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 14. It was hard for me to have fun. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| Total/Partial Raw Score: | | | | | | |
| Prorated Total Raw Score: | | | | | | |
| T-Score: | | | | | | |

*The PROMIS measure was developed for and can be used with children ages 8-17 but was tested in children ages 11-17 in the DSM-5 Field Trials.
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LEVEL 2—Anxiety—Child Age 11–17*
 * PROMIS Emotional Distress—Anxiety—Pediatric Item Bank

Name: _____ Age: _____ Sex: Male Female Date: _____

Instructions to the child: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that during the past 2 weeks you have been bothered by “feeling nervous, anxious, or scared”, “not being able to stop worrying” and/or “not being able to do things you wanted to or should have done because they made you feel nervous” at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often you have been bothered by a list of symptoms **during the past 7 days**. Please respond to each item by marking (✓ or x) one box per row.

| | | | | | | Clinician Use |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|---------------|
| In the past SEVEN (7) DAYS.... | | | | | | Item Score |
| | Never | Almost Never | Sometimes | Often | Almost Always | |
| 1. I felt like something awful might happen. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 2. I felt nervous. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 3. I felt scared. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 4. I felt worried. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 5. I worried about what could happen to me. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 6. I worried when I went to bed at night. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 7. I got scared really easy. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 8. I was afraid of going to school. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 9. I was worried I might die. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 10. I woke up at night scared. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 11. I worried when I was at home. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 12. I worried when I was away from home. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| 13. It was hard for me to relax. | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | |
| Total/Partial Raw Score: | | | | | | |
| Prorated Total Raw Score: | | | | | | |
| T-Score: | | | | | | |

The PROMIS measure was developed for and can be used with children ages 8–17 but was tested in children ages 11–17 in the DSM-5 Field Trials.
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LEVEL 2—Substance Use—Child Age 11–17*

*Adapted from the NIDA-Modified ASSIST

Name: _____ Age: _____ Sex: Male Female Date: _____

Instructions to the child: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that during the past 2 weeks you have been bothered by “having an alcoholic beverage”; “smoking a cigarette, a cigar, or pipe or used snuff or chewing tobacco”; “using drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)”; and/or “using any medicine ON YOUR OWN, that is, without a doctor’s prescription, to get high or change the way you feel.” The questions below ask about these feelings in more detail and especially how often you have been bothered by a list of symptoms during the past two (2) weeks. Please respond to each item by marking (✓ or x) one box per row.

| | Not at All | Less Than a Day or Two | Several Days | More Than Half the Days | Nearly Every Day | Clinician Use |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|---------------|
| During the past TWO (2) weeks, about how often did you ... | | | | | | Item Score |
| a. Have an alcoholic beverage (beer, wine, liquor, etc.)? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | |
| b. Have 4 or more drinks in a single day? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | |
| c. Smoke a cigarette, a cigar, or pipe or use snuff or chewing tobacco? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | |
| During the past TWO (2) weeks, about how often did you use any of the following medicines ON YOUR OWN, that is, without a doctor’s prescription or in greater amounts or longer than prescribed? | | | | | | |
| d. Painkillers (like Vicodin) | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | |
| e. Stimulants (like Ritalin, Adderall) | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | |
| f. Sedatives or tranquilizers (like sleeping pills or Valium) | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | |
| Or drugs like: | | | | | | |
| g. Steroids | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | |
| h. Other medicines | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | |
| i. Marijuana | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | |
| j. Cocaine or crack | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | |
| k. Club drugs (like ecstasy) | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | |
| l. Hallucinogens (like LSD) | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | |
| m. Heroin | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | |
| n. Inhalants or solvents (like glue) | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | |
| o. Methamphetamine (like speed) | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | |

Courtesy of National Institute on Drug Abuse.
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INTAKE QUESTIONNAIRE

Description of Present Problem

What made it important to get help with this problem now?

What have you already tried to do to take care of this problem?

When did you first start to struggle with this problem?

How often is this a problem?

Continuous most days weekly monthly every couple of months

When this is a problem, how intense is it

overwhelming interferes with focus/tasks worrisome minor irritation

If this problem were to go away, what would you be doing differently or how would you be feeling differently than you do now?

Safety Issues:

Please Check the following that are problems - Star any issues you're here for today.

- Oppositional Behavior: _____
- Anger / Aggressive Behavior: _____
- Tantrum: _____
- Changes in mood / interest in activities: _____
- Fears / unwanted thoughts: _____
- Unusual habits / repetitive behavior: _____
- Sleep problems / changes: _____
- Appetite problems / changes: _____
- Suicidal / Homicidal thoughts: _____
- Self harming behaviors: _____
- Alcohol / drug use: _____
- Sexual problems: _____
- Abuse (sexual / physical): _____
- Neglect: _____
- Self Esteem: _____
- Adjustment (death / divorce): _____
- Toileting: _____
- Attention problems: _____
- Hyperactivity: _____
- Relationship problems: _____
- School problems: _____

PREVIOUS ATTEMPTS TO IMPROVE BEHAVIOR/OUTCOME:

Check what successful strategies have been implemented to address these problems or goals.

Verbal reprimands _____ Time out (isolation) _____ Removal or privileges _____

Rewards _____

Physical punishment _____ Give in to child request _____ Avoidance of child _____ Other _____

On the average, how much of the time does (s)he comply with **initial** commands?

Usually _____ Mostly _____ Half the time _____ Occasionally _____ Rarely/never _____

On the average, how much of the time does (s)he **eventually** comply with commands?

Usually _____ Mostly _____ Half the time _____ Occasionally _____ Rarely/never _____

To what extent are you and your spouse consistent with respect to disciplinary strategies.

Usually _____ Mostly _____ Half the time _____ Occasionally _____ Rarely/never _____

Past Psychiatric History:

Current and / or most recent previous counselor(s):

| Counselor Name: | Started | Stopped |
|-----------------|---------|---------|
|-----------------|---------|---------|

Issues addressed at that time?

Should I contact them?

What was most helpful and least helpful about this counseling experience?

Previous mental health inpatient or partial care hospitalizations

| Location: | Date(s) |
|-----------|---------|
|-----------|---------|

| | |
|-----------|---------|
| Location: | Date(s) |
|-----------|---------|

| | |
|-----------|---------|
| Location: | Date(s) |
|-----------|---------|

Should I contact them?

What was most helpful and least helpful about this experience?

Previous Substance Abuse Treatment

| Location: | Date(s) |
|-----------|---------|
|-----------|---------|

| | |
|-----------|---------|
| Location: | Date(s) |
|-----------|---------|

| | |
|-----------|---------|
| Location: | Date(s) |
|-----------|---------|

Should I contact them?

What was most helpful and least helpful about this experience?

Past Trauma History: *For example,* Bullying, physical assaults, combat, discrimination, natural disaster, sexual assaults, sexual molestations, life threatening accidents, child verbal/emotional/physical abuse, child emotional/social neglect, intimate partner violence, intimate partner social/emotional/verbal abuse, others.

| Type | Year(s) | Did you get help? | Is it a current issue? | OK to ask follow up questions? |
|------|---------|-------------------|------------------------|--------------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Is there a family history of mental health or substance abuse?

Mother's Side

Father's Side

Medical History

Medical/Physical Health History – Please Check all he/she has been treated for in the past.

- AIDS Dizziness Nose bleeds Alcoholism Drug abuse
- Pneumonia Abdominal pain Epilepsy Rheumatic Fever Abortion
- Ear infections STD Allergies Eating problems Anemia
- Diarrhea Fainting Sore throat Appendicitis Fatigue
- Scarlet Fever Arthritis Frequent urination Sinusitis Asthma
- Headaches Smallpox Bronchitis Hearing problems Stroke
- Bed wetting Hepatitis Sexual problems Cancer Tonsillitis
- Nausea Chest pains Kidney problems Tuberculosis Chronic pain
- Measles Toothache Colds/Coughs Mononucleosis Constipation
- Mumps Vision problems Chicken Pox Vomiting Sleeping disorders
- Miscarriages Whooping cough Diabetes Seizures Dental problems
- Thyroid problems High blood pressure

Current Physical or Mental Health Treatments

| Condition | Treatment provider | Current? |
|-----------|--------------------|----------|
| | | |
| | | |
| | | |
| | | |
| | | |

How long ago was your child’s last physical? _____ From? _____

Describe your child’s exercise habits

Does (s)he have any problems sleeping?

None ___ Difficulty falling asleep ___ Sleep continuity disturbance ___ Early morning awakening ___ Is (s)he a restless sleeper? _____

Is (s)he sexually active [Y] / [N]? Is it OK to ask follow up questions? [Y] / [N] Clinician notes:

Please list ALL your child's current medications, not just those for mental health.

| Med | Dose | How many times a day? | Prescriber | Reason |
|-----|------|-----------------------|------------|--------|
| | | | | |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |

Does (s)he have bladder control problems at night?
 If yes, how often? _____ If yes, was (s)he ever continent? _____ During the day? _____

Does (s)he have bowel control problems at night?
 If yes, how often? _____ If yes, was (s)he ever continent? _____ During the day? _____

Does (s)he have any appetite control problems?
 Overeats _____ Average _____ Under eats _____ Picky eater _____ (please describe):

CURRENT HEALTH STATUS:

Describe his/her health? Very Good _____ Good _____ Fair _____ Poor _____ Very Poor _____
 How is his/her hearing? Very Good _____ Good _____ Fair _____ Poor _____ Very Poor _____
 How is his/her vision? Very Good _____ Good _____ Fair _____ Poor _____ Very Poor _____
 Gross motor? Very Good _____ Good _____ Fair _____ Poor _____ Very Poor _____
 Fine motor? Very Good _____ Good _____ Fair _____ Poor _____ Very Poor _____
 Speech and language? Very Good _____ Good _____ Fair _____ Poor _____ Very Poor _____

Has (s)he had any chronic health problems (e.g., asthma, diabetes, heart condition)?
 No _____ Yes _____ If yes, please specify: _____

Has (s)he had any accidents resulting in the following? Please give date and cause of injury.
 Broken Bones _____ Severe Lacerations _____ Head Injury _____ Severe Bruises _____
 Stomach Pumped _____ Eye Injured _____ Teeth injured _____ Sutures _____

Other (specify) _____

Family History

Who are the biological parents? Cultural/Ethnicity?

Are they married? If divorced (or deceased) how old was the patient at the time?

If divorced or placed out of home, please describe the custody arraignment or visitation.

Describe the patient's relationship with their parental figures:

Are there other adult figures that are important (grandparents, foster, adoptive, etc.)?

List any siblings in order from oldest to youngest and **include the patient**. Include any important half or step sibling relationships.

Social History

Please list previous placements (foster care, other family members) and dates:

What, if any current life stressors (e.g., work, unemployment, health issues, parenting, caring for elder parents, etc.) are causing stress in your home?

Developmental History:

PRENATAL HISTORY

How was your (or child's mother's) health during pregnancy?

Good ___ Fair ___ Poor ___ DK _____

Did you (or his/her mother) have any illness or complications during pregnancy with this child?
What type?

| |
|--|
| |
| |

How old were you (child's mother) when she became pregnant? _____

Check any of the following substances or medications used during pregnancy?

- | | |
|---|---|
| <input type="checkbox"/> Beer or wine | <input type="checkbox"/> Coffee or other caffeine (Cokes, etc.) |
| <input type="checkbox"/> Hard liquor? | <input type="checkbox"/> Cigarettes? |
| <input type="checkbox"/> Valium (Librium, Xanax) | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Anti-seizure medications | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Sleeping pills | <input type="checkbox"/> Other (please specify) _____ |

Was there toxemia or eclampsia? No ___ Yes ___ DK ___

Was there an Rh factor incompatibility? No ___ Yes ___ DK ___

Was the pregnancy planned? No ___ Yes ___ DK ___

Full Term 9 mos. ___ Early ___ (weeks total _____) Late ___ (weeks total _____)

Signs of fetal distress during labor/birth? No ___ Yes ___ DK ___

Delivery Normal? ___ Breech? ___ Caesarian? ___ Forceps? ___ Induced? ___

What was the child's birth weight? _____

Were there any health complications following birth? Please describe:

| |
|--|
| |
| |

POSTNATAL PERIOD AND INFANCY

Were there early infancy feeding problems? No ___ Yes ___

Was the child colicky? No ___ Yes ___

Were there problems with the infant's alertness? No ___ Yes ___

Did the child have any health/congenital problems? No ___ Yes ___

If yes to any, describe, use back if needed:

| |
|--|
| |
| |

DEVELOPMENTAL MILESTONES

At what age did (s)he sit up? 3-6 mos. ___ 7-9 mos. ___ Over 9 mon. DK ___

At what age did (s)he crawl? 6-12 mos. ___ 13-18 mo. ___ Over 18 mo. ___ DK ___

At what age did (s)he walk? Under 1 yr ___ 1-2 yr ___ 2-3 yr ___ over 3 yr DK ___

At what age did (s)he speak single words (other than mama or dada)? _____

At what age did (s)he string two or more words together? _____

At what age was (s)he toilet trained (bladder control)? _____

At what age was (s)he toilet trained (bowel control)? _____

Approximately how much time did toilet training take from onset to completion? _____

SCHOOL HISTORY:

Current grade: _____ School: _____

Teacher's Name: _____

School Counselor: _____

Has the (s)he ever been in any type of special educational program, and, if so, how long?

Learning disabilities class _____ Duration _____

Behavioral/emotional disorders class _____ Duration _____

Speech and language therapy _____ Duration _____

Other (please specify) _____

Has the (s)he ever been?

(Please describe reasons and give brief details on back if needed):

Suspended from school _____ Number of Suspensions _____ Expelled from school _____

Number of expulsions _____ Retained in grade _____ Number of retentions _____

Have any other instructional modifications been attempted?

None _____ Behavior modification program _____ Daily/weekly report card _____ Other

(please specify) _____

Please describe the type of student or quality of their work.

| |
|--|
| Example: eager to please, but forgetful, distractible. |
| |

Please describe when the school problems (if any) started?

| |
|---|
| Example: Started in 4 th grade – suspensions started in middle school. |
| |
| |
| |

Please describe what the child's social involvement is at school.

| |
|--------------------------------------|
| Example: shy, complains of bullying. |
| |
| |

Legal History

Please list any current legal charges.

Please list any past charges AND convictions (if any) and sentences.
