PHOENIX
Behavioral Health Services LLC
3120 Memorial Drive Two Rivers, WI 54241
Phone (920) 657-1780 Fax (920) 657-1784 www.phoenixbhc.com

Welcome, please carefully read the following policies so you will feel fully informed about how our clinic staff can best serve your needs and can consent to treatment during your time with us. Included is the paperwork that needs to be completed and returned prior to your first appointment. **Please return this paperwork thoroughly completed and signed with your insurance card, and a photo ID 20 days from the welcome letter date or the date the email was sent.**

Clinic Policies

Office Hours

The hours of operations are 8:00 am to 6:00 pm, Monday through Thursday and 8am to 2pm on Friday. Appointments are based on availability.

Telephone Calls / Emergencies

The Intake Coordinator and Support Staff answer our telephones during regular business hours. During office hours, if our Staff are on calls, please leave a message and we will get back to you within 24 business hours. After hours, if you call our mainline our answering service will handle your calls by taking a message or connecting you with an appropriate level of service if you are experiencing a crisis.

Bill of Client's Rights

You have the right to:

- Be informed, both verbally and in writing of your rights prior to entering treatment.
- Expect an explanation of your treatment plan or any procedure, test, or treatment technique in a manner in which you can understand.
- Be informed of the side effects or risks of side effects (if any) from treatment/medications.
- Participate in the development and implementation of your treatment plan
- Refuse treatment to the extent permitted by law and to be informed of any consequences of refusal.
- Every consideration of privacy and confidentiality concerning your care and records. You further have the right to examine, challenge such records, and request a copy of all treatment records upon discharge. You may be charged a reasonable fee for reproduction.
- Expect prompt and adequate treatment in a safe and therapeutic manner. You further have the right to have your physical, emotional, social, and spiritual needs respected.
- Obtain information concerning any relations of this agency to other health services insofar as your care is concerned and to the existence of any professional relationships among individuals who are treating you.
- Reasonable continuity of care including discharge planning.
- Examine and receive an explanation of any charges of fees for services.
- Refuse to be filmed or taped.
- Have a grievance procedure available to you and to have an advocate represent you during the grievance process.
- Bring court action for damages against persons violating your rights.

Grievance Resolution Process

A copy of our program's Grievance Procedure is provided with the packet of information received and is yours to keep. If you feel your rights have been violated, the WI Department of Health Services and we encourage you to discuss it with your therapist. If this does not lead to a resolution, or if you do not wish to discuss with your therapist, you may file a grievance with the Pheonix Behavioral Health Services client rights specialist, please see the Grievance Procedure for contact information. You cannot be threatened or penalized in any way for presenting your concerns.

Payment Policy

Responsibility for the payment of all professional charges remains with the patient or responsible party regardless of insurance coverage. If you have insurance, we ask you to make your co-payment at each visit. If you do not have insurance, the entire amount must be paid at the time of service unless prior payment arrangements have been made. Returned checks will receive a $35.00 charge.

Insurance Coverage

Phoenix Behavioral Health Services, LLC is a certified outpatient mental health facility in the State of Wisconsin. We are authorized to receive mandated benefits under Wisconsin State Statute 632.89. When you schedule your appointment with us, we will contact your insurance company to verify eligibility and coverage. It is your responsibility to call your insurance to verify that Phoenix, as well as your therapist, are in-network providers, and that therapy and psychological testing are covered under your insurance plan. If you do not complete this verification, you may be responsible for the entire cost of services.

Cancellations and No-Call/No-Shows

We ask you to notify our office 24 hours in advance for any cancellation. **Failure to call may result in cancellation of future appointments and placed on same day scheduling, and/or a charge of $65.00 for the missed session.** Please cancel if you are ill, for your safety and the safety of others in the clinic. In an emergency situation, the therapist may suspend this fee. If you are late for an appointment, the time missed will be part of your therapy time. If the therapist is late, he/she will only charge for the time actually spent with you. If you are late, the therapist will call you to offer a shorter session and check on your wellbeing. If you cannot make it for a shorter session, you do not answer the call, or do not arrive for the appointment, prior to being 15-minutes late, you will be considered a no-call/no-show. At this time, the therapist and PBHS will make attempts to reschedule and receive an update on your wellbeing.

If you do not respond you will receive a letter requiring you to call PBHS and schedule an appointment, request discharge, or do nothing and be automatically discharged. If you request to discharge you are eligible for services again when ready. If you are automatically discharged, you will be eligible to complete a new intake after 90 days at which time you can submit new intake paperwork and be scheduled or place on the current waiting list.

If you engage in no call no show behavior, described above, on two occasions in a consecutive manner for intake or ongoing sessions, you will be notified by phone when scheduling the next session that a third no call no show will result in discharge and a letter will be sent reviewing the information.

If you engage in no call or no show behavior on three occasions in a consecutive manner for intake or ongoing sessions, you will automatically be sent a discharge letter with recommendations for referrals and opportunity to reengage when you ready, but not sooner than 90 days.

Locations:

Two Rivers - 3120 Memorial Drive Two Rivers, WI 54241
Green Bay - 2700 Vernon Dr Suite #311 Green Bay, WI 54304
Stevens Point - 2607 Post Rd Suite F Stevens Point, WI 54881

Thank you for choosing Phoenix Behavioral Health Services, LLC.

PHOENIX BEHAVIORAL HEALTH SERVICES, LLC

LAST NAME	FIRST	MI	PHONE	BIRTH DATE	AGE

ADDRESS	SS#	Gender_____

CITY	STATE	ZIP	

EMAIL ADDRESS- required	Client School

DESCRIPTION OF PROBLEM	WHO REFERRED YOU

FOR MINOR CLIENTS - IS THERE A CUSTODY AGREEMENT - YES (Please provide a copy) NO

HOW DID YOU HEAR ABOUT US? (check)	INTERNET _____	DR. REFERRAL _____	PERSONAL REFERRAL _____
	COURT ORDERED _____	INSURANCE PPO LIST _____	OTHER (please list)

PARENT(S) NAMES	PARENTS EMPLOYER	PARENTS PHONE

PARENT(S) NAMES	PARENTS EMPLOYER	PARENTS PHONE

GUARDIAN NAME	GUARDIAN ADDRESS	GUARDIAN PHONE

BILLING AND/OR INSURANCE INFORMATION (PLEASE LIST IN ORDER TO BE SUBMITTED).

COMMERCIAL INSURANCE _____	PRIMARY INS. CO	SECONDARY INS. CO
MEDICARE _____	NAME OF POLICY HOLDER - required	NAME OF POLICY HOLDER - requried
MEDICAID _____	BIRTH DATE OF POLICY HOLDER - required	BIRTH DATE OF POLICY HOLDER-required
MEDICAID HMO PLAN _____	ID#	ID#
PRIVATE PAY _____	GROUP # OR NAME	GROUP # OR NAME
ADDRESS OF POLICY HOLDER (If different than above)		

All professional services are charged to the client. Phoenix will bill your insurance as a courtesy. However, the client is responsible for all fees regardless of insurance coverage. We ask that insurance clients make their co-pays at the time of each session. Private pay clients must pay the entire amount at time of visit, unless other payment agreements have been made.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize the release of any information necessary to determine benefits associated with visits to Phoenix Behavioral Health Services, LLC and request payment directly to them for services provided. I recognize and accept responsibility for any balance remaining after payment of benefits associated with my health insurance policy

Revalidation of HIPAA & Consent to Treat and Contact

I acknowledge receipt of the HIPAA Notice of Privacy Practices, grant permission to Phoenix Behavioral Health Services, LLC. to contact me and grant consent to treat and acknowledge program policies & procedures of Phoenix Behavioral Health Services, LLC.

CLIENT or LEGAL REPRESENTIVE SIGNATURE

DATE

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PAYMENT AND CREDIT POLICY

I understand that PBHS charges the following fees for professional services.

LCSW, LMFT, LPC RATES

Diagnostic Interview/Intake Assessment (1st Visit) $230.00 Psychotherapy/Family Therapy $200.00 and Group Therapy (1 hour) per Individual $50.00

PHD RATES

Diagnostic Interview/Intake Assessment $250.00

Psychological testing per unit $180.00-230.00 and Psychotherapy/Family Therapy $220.00

The responsibility for the payment of all professional charges remains with the patient or responsible party regardless of insurance coverage. If you choose to use your insurance, we do file claims with your insurance companies (primary and secondary) and verify your insurance benefits, but we **cannot guarantee payment for services by your insurance provider.**
Therefore, **you are responsible for the services provided.** If payment from your insurance is not received in 30 days, the account is due and payable in full. ANY CHECKS RETURNED FOR N.S.F WILL BE CHARGED A $35.00 FEE. If your account is past due more than 90 days without payment, we will pursue payment through a third-party collection agency.

Insurance clients are required to make their co-payment (the portion your insurance does not cover) at each visit. This will be collected by the administrative support staff before the start of your session. **Private pay clients** must pay the entire fee at the time of service unless prior arrangements have been made.

You are responsible for notifying us of any change in your insurance coverage, your benefits, your name, address, and telephone number.

If you need to cancel your appointment, please call us 24 hours in advance. **Failure to call may result in cancellation of future appointments, placement on same day scheduling, and a charge of $65.00 for the missed session.** If we are not available to take your call, you may leave a message with our 24-hour answering service.

PAYMENTS MUST BE CURRENT IN ORDER TO RECEIVE SERVICES.

CLIENT FINANCIAL AGREEMENT

I make this agreement with the knowledge and understanding that I accept full responsibility and liability for any and all charges incurred by me and guarantee timely payment of same.

Client Name _____

Client or Legal Representative Signature _____ Date _____

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Client Informed Consent & Acknowledgement of Clinic Policies and Procedures

This is to acknowledge that I have been provided with and understand the following information.

1. The general nature and purpose for outpatient treatment services & the services available through the clinic, including benefits, administration, and side effects of treatment.
2. Client responsibilities relating to treatment.
3. Alternatives to treatment modes.
4. Consequences of not receiving proposed treatment.
5. "Bill of Client Rights"
6. Clinic hours & treatment costs.
7. How to access emergency services.
8. Client rights and grievance procedure.
9. Criteria for discharge from treatment.
10. 24 hours advance notice for cancellation of an appointment.
11. My rights to request consultation with consulting psychiatrist or psychologist.
12. Confidentiality and the limits of confidentiality as it relates to client information.

I consent to the treatment plan as described by my Therapist until such time as I terminate treatment with Phoenix Behavioral Health Services, LLC. or 15 months from the date signed. I understand that I may withdraw informed consent for treatment at any time by submitting such a request in writing to my Treatment Therapist _____ initial

HIPAA NOTICE OF PRIVACY PRACTICES:

I acknowledge receipt of the HIPAA Notice of Privacy Practices for Phoenix Behavioral Health Services, LLC. Questions or Concerns about privacy rights, Phoenix Behavioral Health Service's privacy-related policies or the information contained in this notice, contact Chief Privacy Officer of Phoenix Behavioral Health Services at 3120 Memorial Drive, Two Rivers, WI 54241, 920-657-1780 or at info@phoenixbhc.com

I have declined a paper copy of HIPAA Practices _____ initial or
I have received a paper copy of HIPAA Practices _____ initial

CONSENT TO CONTACT:

I give my permission to Phoenix Behavioral Health Services, LLC and its Affiliates or contractors to contact me for any purpose at the current or any future numbers that are provided for landline telephone, cellular telephone or any wireless device including the use of automated dialing equipment, prerecorded voice, or text messages.
I have agreed to be contacted by employees of Phoenix BHS _____ initial and messages left about scheduling _____ initial

Client Name (printed)_____

Client or Legal Representative Signature_____ Date_____
Clients may request a copy of this consent form if they wish to have one for their records.

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INFORMED CONSENT CHECKLIST FOR TELEMEDICINE SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for Telemedicine services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the counselor will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session. If you are not at your home address on file with Phoenix Behavioral Health Services, LLC it is your responsibility to inform the provider of your physical address while receiving telemedicine services.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the counselor 24 hours in advance in accordance with our Welcome Letter and Cancellations Policy by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in Telemedicine sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- Your counselor or BCBA may determine that due to certain circumstances, Telemedicine is no longer appropriate and that sessions should resume in-person.

I consent to use of Telemedicine as described above.

_____

Client Name Printed

_____ _____

Client or Legal Representative Signature Date

Client Rights and the Grievance Procedure for Community Services*

for Clients Receiving Services in Wisconsin for Mental Illness, Alcohol or Other Drug Abuse, or Developmental Disabilities

CLIENT RIGHTS

When you receive any type of service for mental illness, alcoholism, drug abuse, or a developmental disability, you have the following rights under Wisconsin Statute sec. 51.61 (1) and DHS 94, Wisconsin Administrative Code:

PERSONAL RIGHTS

- You must be treated with dignity and respect, free from any verbal, physical, emotional, or sexual abuse.
- You have the right to have staff make fair and reasonable decisions about your treatment and care.
- You may not be treated unfairly because of your race, national origin, sex, age religion, disability, or sexual orientation.
- You may not be made to work except for personal housekeeping chores. If you agree to do other work, you must be paid.
- You may make your own decisions about things like getting married, voting, and writing a will, if you are over the age of 18, and have not been found legally incompetent.
- You may use your own money as you choose.
- You may not be filmed, taped, or photographed unless you agree to it.

TREATMENT AND RELATED RIGHTS

- You must be provided prompt and adequate treatment, rehabilitation, and educational services appropriate for you.
- You must be allowed to participate in the planning of your treatment and care.
- You must be informed of your treatment and care, including alternatives to and possible side effects of treatment, including medications.
- No treatment or medication may be given to you without your written, informed consent, **unless** it is needed **in an emergency** to prevent serious physical harm to you or others, or **a court orders it**. [If you have a guardian, however, your guardian may consent to treatment and medication on your behalf.]
- You may not be given unnecessary or excessive medication.
- You may not be subject to electroconvulsive therapy or any drastic treatment measures such as psychosurgery or experimental research without your written informed consent.
- You must be informed in writing of any costs of your care and treatment for which you or your relatives may have to pay.
- You must be treated in the least restrictive manner and setting necessary to achieve the purposes of admission to the program, within the limits of available funding.

RECORD PRIVACY AND ACCESS

Under Wisconsin Statute sec. 51.30 and DHS 92, Wisconsin Administrative Code:

- Your treatment information must be kept private (confidential), unless the law permits disclosure.
- Your records may not be released without your consent, unless the law specifically allows for it.
- You may ask to see your records. You must be shown any records about your physical health or medications. Staff may limit how much you may see of the rest of your treatment records while you are receiving services. You must be informed of the reasons for any such limits. You may challenge those reasons through the grievance process.
- After discharge, you may see your entire treatment record if you ask to do so.
- If you believe something in your records is wrong, you may challenge its accuracy. If staff will not change the part of your record you have challenged, you may file a grievance and/or put your own version in your record.
- A copy of sec. 51.30, Wis. Stats., and/or DHS 92, Wisconsin Administrative Code, is available upon request.

GRIEVANCE PROCEDURE AND RIGHT OF ACCESS TO COURTS

- Before treatment is begun, the service provider must inform you of your rights and how to use the grievance process. A copy of the Program's Grievance Procedure is available upon request.
- If you feel your rights have been violated, you may file a grievance.
- You may not be threatened or penalized in any way for presenting your concerns informally by talking with staff, or formally by filing a grievance.
- You may, instead of filing a grievance or at the end of the grievance process, or any time during it, choose to take the matter to court to sue for damages or other court relief if you believe your rights have been violated.

GRIEVANCE RESOLUTION STAGES

Informal Discussion (Optional)

You are encouraged to first talk with the provider or staff about any concerns you have. However, you do not have to do this before filling a formal grievance with your service provider.

Grievance Investigation-Formal Inquiry

- If you want to file a grievance, you should do so within 45 days of the time you become aware of the problem. The program manager for good cause may grant an extension beyond the 45 day limit.
- The program's Client Rights Specialist (CRS) will investigate your grievance and attempt to resolve it.
- Unless the grievance is resolved informally the CRS will write a report within 30 days from the date you filed the formal grievance. You will get a copy of the report.
- If you and the program manager agree with the CRS's report and recommendations, the recommendations shall be put into effect within an agreed upon time frame.
- You may file as many grievances as you want. However, the CRS will usually only work on one at a time. The CRS may ask you to rank them in order of importance.

Program Manager's Decision

If the grievance is not resolved by the CRS's, you may request the program manager investigate your grievance. The program manager or designee shall prepare a written decision within 10 days of your request with receipt of the CRS's report. You will be given a copy of the decision.

County Level Review

- If you are receiving services from a county agency, or a private agency and a county agency is paying for your services, you may appeal the program manager's decision to the County Agency Director. You must make this appeal within 14 days of the day you receive the program manager's decision. You may ask the program manager to forward your grievance or you may send it yourself.
- The County Agency Director must issue his or her written decision within 30 days after you request this appeal.

State Grievance Examiner

- If your grievance went through the county level of review and you are dissatisfied with the decision, you may appeal it to the State Grievance Examiner.
- If you are paying for your services from a private agency, you may appeal the program manager's decision directly to the State Grievance Examiner.
- You must appeal to the State Grievance Examiner within 14 days of receiving the decision from the previous appeal level. You may ask the program manager to forward your grievance to the State Grievance Examiner or you may send it yourself. The address is: State Grievance Examiner, Division of Care and Treatment Services (DCTS), PO Box 7851, Madison, WI 53707-7851.

Final State Review

Any party has 14 days of receipt of the written decision of the State Grievance Examiner to request a final state review by the Administrator of the Division of Care and Treatment Services or designee. Send your request to the DCTS Administrator, PO Box 7851, Madison, WI 53707-7851.

You may talk with staff or contact your Clients Rights Specialist, whose name is shown below, if you would like to file a grievance or learn more about the grievance procedure used by the program from which you are receiving services:

YOUR CLIENT RIGHTS SPECIALIST IS: John Laliberté, 920-657-1780

NOTE: There are additional rights within sec. 51.61(1) and DHS 94, Wisconsin Administrative Code. They are not mentioned here because they are more applicable to in-patient and residential treatment facilities. A copy of sec.51.61, Wis.Stats. and/or DHS 94, Wisconsin Administrative Code is available upon request.

STATE OF WISCONSIN DEPARTMENT
OF HEALTH SERVICES
Division of Care and Treatment Services www.dhs.wisconsin.gov
P-23112 (09/2016)

_____

Client name

_____ _____

Client or Legal Guardian Signature Date

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MEDICATION HISTORY

Client Name ____ Date ________________________

Name of Medication		Dosage (mg/ml)	Instructions	How is medication taken?	Prescribing Physician/Psychiatrist
	Date Began: Date Ended:		__ 1x daily __ 2x daily __ 3x daily __ 4x daily __ as needed __ other____________	__ Topical __ Oral __ Injection __ Other____________	
	Date Began: Date Ended:		__ 1x daily __ 2x daily __ 3x daily __ 4x daily __ as needed __ other____________	__ Topical __ Oral __ Injection __ Other____________	
	Date Began: Date Ended:		__ 1x daily __ 2x daily __ 3x daily __ 4x daily __ as needed __ other____________	__ Topical __ Oral __ Injection __ Other____________	
	Date Began: Date Ended:		__ 1x daily __ 2x daily __ 3x daily __ 4x daily __ as needed __ other____________	__ Topical __ Oral __ Injection __ Other____________	
	Date Began: Date Ended:		__ 1x daily __ 2x daily __ 3x daily __ 4x daily __ as needed __ other____________	__ Topical __ Oral __ Injection __ Other____________	
	Date Began: Date Ended:		__ 1x daily __ 2x daily __ 3x daily __ 4x daily __ as needed __ other____________	__ Topical __ Oral __ Injection __ Other____________	
	Date Began: Date Ended:		__ 1x daily __ 2x daily __ 3x daily __ 4x daily __ as needed __ other____________	__ Topical __ Oral __ Injection __ Other____________	

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Child Intake & Assessment

Please complete the following to the best of your ability.

Child's name _____ **Age** _____ **Birth date** _____**Race or Ethnicity** _____

Biological Child _____ Adopted Child _____ Foster Care Child _____ (How long in your home?) _____

Sex assigned at birth: _____ Gender: _____ My child's pronouns are: _____

Primary Caregiver: _____ Age _____ Occupation _____

Check ✓ if deceased _____ Age of death _____ Cause of death _____

Primary Caregiver: _____ Age _____ Occupation _____

Check ✓ if deceased _____ Age of death _____ Cause of death _____

Legal Guardian: _____ check ✓ if same as above: _____

Presenting Concern:

State in your own words the nature of the concern you are seeking help for: _____

_____

_____

When did the concern begin? (Approximate dates and circumstances): _____

_____

_____

What do you hope to accomplish through the counseling process?

_____

_____

Current Mental Health Concerns - Please check ✓ any area where you think you may have a concern:

	✓		✓		✓		
Anger/Temper		Guilt		Mood Swings		Stress/Burnout	
Antisocial behavior		Hyperactivity		Oppositional/Defiant		Suicidal Thoughts	
Anxiety/Nervousness		Hopelessness		Relationships		Weight Loss/Gain	
Concentration		Indecision		Restrictive/overeating		Other:	
Depression		Irritability		Self-Concept			
Fears/Phobias		Memory		Self-Injury			

Does your child use alcohol or drugs? Yes No If yes, explain: _____

Siblings (List name(s) from oldest to youngest): _____

_____

Who lives in your home? _____

_____

Developmental History:

Birthplace: _____

Were there any problems during pregnancy? Yes No If yes, explain: _____

Were there any complications during labor and delivery? Yes No If yes, explain: _____

Did the caregiver experience any depression during or after pregnancy? Yes No If yes, explain: _____

At what age did your child talk? _____ walk? _____ become toilet-trained? _____

Check ✓ if any of the following occurred during your child's life:

	✓	Age of child	Explain
Changes in the primary caregiver			
Depression or physical severe illness of the caregiver			
Emotional Abuse			
Frequent or lasting painful illness			
Hospitalization			
Long-term separation from primary caregiver (more than two weeks)?			
Main caregiver struggled with parenting skills			
Major surgery			
Mental Abuse			
Neglect			
Physical Abuse			
Severe colic lasting more than one month			
Sexual Abuse			
Switches in daycare			
Traumatic Experience			
Verbal abuse or threats of violence			
Other:			

Parenting:

Describe your relationship with your child (past & present): _____

_____

_____

How do you feel about being a parent? _____

_____

How do you handle problems with your children? _____

_____

_____

What forms of discipline do you use? _____

_____

To what extent do you rely on your children for support (emotional and/or financial)? _____

_____

Please describe your parenting support system: _____

_____

Do you or your child have any Spiritual and/or cultural variables that may impact treatment? Yes No

If yes, please explain _____

Check ✓ if your child has experienced (past or present) any of the following behaviors:

	✓	Age of child	Explain
Affectionate or Avoidant (circle one)			
Blank spells			
Clumsy			
Daredevil behavior			
Impulsive			
Not easily comforted			
Physical exercise			
Shyness			
Sleeping problems			
Stimming (repetitive motions or behaviors)			
Temper tantrums			
Other:			

Does your child make and keep friends easily? Yes No

Has your child ever been bullied by a peer? Yes No If yes, explain: _____

Legal Concerns: _____

Education

Child's School _____ Grade _____ Teacher _____

School Social Worker/Psychologist _____

Highest grade completed: _____ Degree(s) completed: _____

Does your child have any academic, behavioral, or social difficulties in school? Yes No If yes, explain: _____

_____

_____

Strengths in school: _____

_____

What has the school informed you about your child's behavior and or academics?

_____

_____

Recreation & Leisure

What are your child's hobbies and interests? _____

_____

How often does your family vacation? _____

Medical History

Do you have any concerns about your child's physical health? Yes No Please explain: _____

_____

Is your child currently under the care of a physician for treatment of a physical or emotional condition? Yes No

If yes, please list the physician's name, reason for treatment, and date last seen _____

_____

Current Physician: _____ Last Examination and Results: _____

Please check ✓ any of the following that apply to you or a family member (currently or in the past):

	Child ✓	Family Member ✓		Child ✓	Family Member ✓
Alcohol/Drug Abuse			Heart Palpitations		
Allergies			High Blood Pressure		
Arthritis			Hyperventilation		
Asthma			Hypoglycemia		
Cancer			Incontinence		
Cirrhosis			Infectious Disease		
Constipation			Kidney Disease		
Diabetes			Neurological Disease		
Epilepsy/Seizures			Pulmonary Disease		
Gastrointestinal			Sleep Disorder		
Glaucoma			Tension		
Head Trauma			Thyroid Disease		
Headaches/Migraines			Vomiting		
Hearing Impairment			Other:		
Heart Disease					

Mental Health History

List any past mental health history for any <u>family</u> members: _____

_____

Has your child had any previous testing or counseling? Yes No If yes, with whom and when? _____

_____

Was previous counseling or treatment helpful? Yes No If yes, explain: _____

_____

Any history of psychiatric hospitalizations? Yes No If yes, dates and reasons? _____

_____

Please check ✓ any of the following that often apply to your child:

	✓		✓		✓		✓		✓		✓
Anger		Depressed		Frustrated		Joyful		Regretful		Tired	
Annoyed		Energetic		Helpless		Lonely		Restless		Other:	
Anxious		Envious		Happy		Optimistic		Relaxed			
Bored		Excited		Hopeful		Peaceful		Sad			
Content		Fearful		Hopeless		Pessimistic		Tense			

Parent/Guardian Signature:_____ **Date:** _____