Trinity Behavioral Health

931-919-2641 (Office) 931-919-2643 (Fax)

Consent to Treatment for Minor

_______I am hereby seeking and consenting treatment by the therapist named below for my minor child. I understand that developing a treatment plan with this therapist and regularly reviewing work toward meeting the treatment goals for my child are in my best interest. I agree to play an active role with my child/adolescent in this process.

_______I understand that no promises have been made to me as to the results of treatment for my child or of any procedures provided by this therapist.

_______I am aware that I may stop my child's treatment with this therapist at any time. I am aware I will still be responsible for unpaid services my child has already received. I understand that I (or my child) may lose other services or may have to deal with other problems if I stop treatment. (For example, if my child's treatment has been court-ordered, I will have to answer to the court.)

_______I know that I must call to cancel an appointment at least **24 hours** before the time of the appointment. If the appointment is scheduled for a **Monday**, I must call **no later than Friday** before appointment. Cancellations must be made with a staff member (voice mails will not be accepted unless emergency situation). If I do not cancel and do not show up, I will be charged the **full rate** for that appointment ($130.00). This fee may be charged to my credit card number on file within **7 days** of the charge, if I have not made other arrangements to pay the fee.

_______I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I or my child receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

_______I am aware that all payments to include copayments, coinsurance and any deductibles required by my insurance (if not private pay) are due prior to services being provided.

My signature below shows that I understand and agree with all of these statements.

_______________________________________ _______________________

Signature of client (or person acting for client) Date

_______________________________________ _______________________

Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_______________________________________ _______________________

Signature of therapist Date

❑ Copy accepted by client ❑ Copy kept by therapist ❑ Copy to medical record

ALL FEES ARE DUE AT TIME OF SERVICE

Trinity Behavioral Health

Registration Form

Client Name (Last, First, Middle Initial):		Social Security Number:	Date of Birth:	Age:
Occupation/Employer:	Referred By:	Gender: Male Female		
Relationship Status: Single Single, Intimately Involved Married Divorced Separated Widowed		Cultural Affiliation *(Check all that apply)*: African American American Indian Asian Caucasian Hispanic Other:		
Home Address:				
E-mail Address:		Other Family Members Seen Here?	DCS/Court Involvement: Yes No If yes, provide contact info:	
Do you wish to receive text message reminders? Yes No		Home Phone: Work Phone: Cell Phone:		
May we leave a message? Home: No Yes Work: No Yes Cell: No Yes Email: No Yes Other: ____________				
Cell Phone Carrier:				

INSURANCE INFORMATION (Please give card to receptionist)*

Person Responsible for Bill:	Relationship to Client: (Self or Parent)	Date of Birth:	Address:	Phone:
Name of Primary Insurance:		Policy Number:		
Group Number:		Name of Employer:		
Policy Holder's Name:		Policy Holder's DOB:		
Policy Holder's SSN:	Relationship to Client:	Policy Holder's Address:		
Secondary Insurance Name:		Secondary Insurance Policy/Group #:		
Secondary Group Number:		Type of Secondary (Medicaid, Non-Custodial Parent, Retiree, etc):		
Secondary Policy Holder's Name:		Secondary Policy Holder's DOB:		
Secondary Policy Holder's SSN:	Relationship to Client:	Secondary Policy Holder's Address:		

In Case of Emergency: Spouse (if married)/Parent (if minor) Information/Local Friend (if unmarried)

Name of Spouse/Parent/Friend (Last, First, Middle Initial):	Social Security Number (N/A for Friend only):	Date of Birth:
Address:	Phone Number:	
Printed Name of Client (or Parent/Guardian if minor)	Signature of Client (or Parent/ Guardian if minor)	Date:

Please advise reception/office staff of ALL medical/behavioral health insurance. The office staff can help you determine if an insurance is primary vs. secondary. Failure to provide all insurance information may lead to insurance denials, and subsequently TBHS billing the responsible person for the full rate of services provided.

I understand that payment for today's visits and future visits are due at the time of treatment. Charges for the collection of delinquent accounts, court costs, and/or reasonable attorney's fees will be added to the total balance; including contingent fees to collection agencies of not less than 35%, such contingency fees to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency. A photocopy of this authorization shall be considered as effective and valid as the original.

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Fee Schedule for Services NOT Covered by Insurance

In many cases, health insurance is utilized by our clients to cover their mental health counseling/therapy expenses. However, insurance companies often only cover select services to include the following: Initial Intake Session, Individual Psychotherapy, and Family Psychotherapy. Occasionally, your insurance may cover crisis intervention, which includes an appointment provided within a specific time frame with a focus on intervening when a consumer is in crisis as an attempt to divert from a higher level of care, such as hospitalization.

Your health insurance, **WILL NOT** cover the following services, often requested by consumers: correspondence between consumer, family members, and other interested parties (i.e. lawyers, case managers, family therapists/counselors, etc), case write ups and/or treatment summaries, court appearances and/or testifying in court, and a variety of other circumstances, not included in this description.

Our practice can assist by discussing your options for you and/or your families' therapeutic issues, answer basic questions, and provide basic correspondence with no additional cost to you with a focus on providing you and your family quality care. However, due to the multitude of requests that our office often receives with regards to requests by our consumers to perform duties that require a significant amount of time, and is not covered by insurance, we have developed the following fee schedule to be followed by all therapists/staff.

If you have any questions regarding our fee schedule, please do not hesitate to speak to La Vaun Kelley, LPC-MHSP, Owner/Clinical Director and/or Ian Corland, Director of Operations for further information.

Service	Unit of Measure	Minimum Charge	Basis of Charge
Telephone Calls, conferences, meetings, etc	Time (First 15 minutes/day per client are free of charge)	15 minutes increments (beyond the first 15 free minutes/day per client)	Hourly Rate
Copies (to include copy of chart)	Per Page	None	$.30/page
Fax (more than 5 pages)	Per Page (first 5 are free of charge)	None	$1.00/page
Psychoeducational Group	Per session	$30.00	Group Rate/Discounted
Court Appearance	Time	1 hour (a deposit of $500 is required at time of initial request for court appearance)	Hourly rate
Travel (to include court appearances outside of Montgomery County)	Time	Mileage plus hourly rate	$.55/mile plus hourly rate based on Mapquest from office location to destination.

Hourly Rate : $130/hr

Client Signature ____________ Date ____________

Staff Signature ____________ Date ____________

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Agreement for Parents

(Limitations and Goal of Psychotherapy with a Child of Divorce.)

Psychotherapy can be a very important resource for children regardless of the reason for seeking treatment. Establishing a therapeutic alliance outside of the home can:

•Facilitate open and appropriate expression of the strong feelings which routinely accompany family transitions (like deployments, divorce, etc), academic difficulties, behavioral issues, etc..

•Provide an emotionally neutral setting in which children can explore these feelings.

•Help children understand and accept the changes that occur at different stages of development (middle school, high school, academic expectations, peers, etc), parental discourse, blended families,

•Offer feedback and recommendations to a child's caregivers based on knowledge of the child's specific emotional needs and developmental capacities.

However, in cases of divorce, custodial issues, etc, the usefulness of such therapy is extremely limited when the therapy itself becomes simply another matter of dispute between parents. With this in mind, and in order to best help your child, I strongly recommend that each of the child's caregivers (e.g., parents, stepparents, daycare workers, guardian ad litem [GAL], etc.) mutually accept the following as requisites for the child's participation in therapy.

1. As your child's psychotherapist, it is my primary responsibility to respond to your child's emotional needs. This includes, but is not limited to, contact with your child and each of his or her caregivers, and gathering information relevant to understanding your child's welfare and circumstances as perceived by important others (e.g., pediatrician, teachers, other psychologists, social workers, etc.). In some cases, this may include a recommendation that you consult with a physician, should matters of your child's physical health be relevant to this therapy.

2. I ask that all caregivers remain in frequent communication regarding this child's welfare and emotional well-being. Open communication about his or her emotional state and behavior is critical. In this regard, I invite each of you to initiate frequent and open exchange with me as your child's therapist.

3. I ask that all parties recognize and, as necessary, reaffirm to the child, that I am the child's helper and not allied with any disputing party.

4. I strongly recommend that all caregivers involved choose to participate in psychoeducational groups in which separating and divorced parents learn basic strategies for conducting a divorce in the best interests of the child. I can refer you to such programs.

5. Please be advised regarding the limits of confidentiality as it applies to psychotherapy with a child in these circumstances:
• I keep records of all contacts relevant to your child's well-being. These records are subject to court sub-poena and may, under some circumstances, be solicited by parties to your divorce, including your attorneys.
• Any matter brought to my attention by either parent regarding the child may be revealed to the other parent. Matters which are brought to my attention that are irrelevant to the child's welfare may be kept in confidence. However, these matters may best be brought to the attention of others, such as attorneys, personal therapists or counselors.

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* I am legally obligated to bring any concern regarding the child's health and safety to the attention of relevant authorities (TN Department of Children Services). When possible, should this necessity arise, I will advise all parties regarding my concerns.

6. This psychotherapy will not yield recommendations about custody. In general, I recommend that parties who are disputing custody strongly consider participation in alternative forms of negotiation and conflict resolution, including mediation and custody evaluation, rather than try to settle a custody dispute in court.

7. Payment for my services is due, in full, at the time of service in a manner agreed to by all parties involved. Any outstanding balance accrued (for example, in conference with attorneys, the GAL, or teachers), must be paid promptly and in full. Please see "Fee Schedule" for any fees that may occur, which will not be covered by behavioral health insurance.

Your understanding of these points and agreement in advance of starting this therapy may resolve difficulties that would otherwise arise and will help make this therapy successful. Your signature, below, signifies that you have read and accept these points.

Caregiver's name ______________________ Date ____________

~~Printed name~~ Sign ______________________

Caregiver's name ______________________ Date ____________

Printed name ______________________

Child's name ______________________ Date of birth ____________ Age ____

Therapist ______________________ Date ____________

❑ Copy accepted by client ❑ Copy in medical records

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

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Where your challenges meet solutions

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the relevant professional practice standards for your therapist. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

- **For Treatment**. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization. We may also contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you.

- **For Payment**. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

- **For Health Care Operations.** We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

- **Required by Law.** Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

- **Without Authorization**. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

- **Child Abuse or Neglect.** We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

- **Judicial and Administrative Proceedings.** We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

- **Deceased Patients.** We may disclose PHI regarding deceased patients as mandated by state law. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate.

- **Medical Emergencies.** We may use or disclose your protected health information in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

- **Family Involvement in Care.** We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

- **Health Oversight.** If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.
- **Law Enforcement.** We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.
- **Specialized Government Functions.** We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.
- **Public Health.** If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.
- **Public Safety.** We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

- **Research.** PHI may only be disclosed after a special approval process.

- **Verbal Permission.** We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

- **With Authorization**. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

Trinity Behavioral Health
Services

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Psychosocial History—Children and Adolescents (< 18)

Client's name: ______________________________ Date: __________________

Gender: ____F ____ M Date of birth: _________ Age: ______ Grade in school: __________

Form completed by (if someone other than client): ______________________________

Address: __________________ City: ______________ State: ________ Zip: ________

Phone (home): _________________ (work): __________________ Ext: ____________

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

Primary reason(s) for seeking services:

____ Anger management ____ Anxiety ____ Coping ____ Depression
____ Eating disorder ____ Fear/phobias ____ Mental confusion ____ Sexual concerns
____ Sleeping problems ____ Addictive behaviors ____ Alcohol/drugs ____ Hyperactivity
____ Other mental health concerns (specify): ____

____

FAMILY HISTORY

PARENTS

With whom does the child live at this time? ____

Are parent's divorced or separated? ____

If Yes, who has physical custody? ____

What is the visitation agreement? How often does child see non-custodial parent?_______________

____

Where the child's parents ever married? ____ Yes ____ No

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? ____ Yes ____ No

If Yes, describe: ____

CLIENT'S MOTHER

Name: ___________ Age: ________ Occupation: __________________ ____FT ____PT

Where employed: _________________________ Work phone: ____________________

Mother's education: ____

Is the child currently living with mother? ____ Yes ____ No

___ Natural parent ___ Stepparent ___ Adoptive parent ___ Foster home ___ Other (specify): _______

Is there anything notable, unusual or stressful about the child's relationship with the mother?

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____ Yes ____ No If Yes, please explain : ______________________________

____

How is the child disciplined by the mother? ______________________________

For what reasons is the child disciplined by the mother? ______________________________

CLIENT'S FATHER

Name: ________________ Age: __________ Occupation: ________________ ___ FT ___ PT

Where employed: ______________________________ Work phone: ________________

Father's education: ______________________________

Is the child currently living with father? ____ Yes ____ No

___ Natural parent ___ Stepparent ___ Adoptive parent ___ Foster home ___ Other (specify): ________

If there anything notable, unusual or stressful about the child's relationship with the father?

____ Yes ____ No If Yes, please explain: ______________________________

____

How is the child disciplined by the father? ______________________________

For what reasons is the child disciplined by the father? ______________________________

CLIENT'S SIBLINGS AND OTHERS WHO LIVE IN THE HOUSEHOLD

Name of Siblings	Age	Gender		Lives		Quality of relationship with the client		
________________	___	___ F	___ M	___ home	___ away	___ poor	___ average	___ good
________________	___	___ F	___ M	___ home	___ away	___ poor	___ average	___ good
________________	___	___ F	___ M	___ home	___ away	___ poor	___ average	___ good
________________	___	___ F	___ M	___ home	___ away	___ poor	___ average	___ good

Others living in the household				Relationship (e.g., cousin, foster child)			
____________	___	___ F	___ M	________________	___ poor	___ average	___ good
____________	___	___ F	___ M	________________	___ poor	___ average	___ good
____________	___	___ F	___ M	________________	___ poor	___ average	___ good
____________	___	___ F	___ M	________________	___ poor	___ average	___ good

Comments: ______________________________

____

____

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FAMILY HEALTH HISTORY

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

____ Allergies	____ Deafness	____ Muscular dystrophy
____ Anemia	____ Diabetes	____ Nervousness
____ Asthma	____ Glandular problems	____ Perceptual motor disorder
____ Bleeding tendency	____ Heart diseases	____ Mental retardation
____ Blindness	____ High blood pressure	____ Seizures
____ Cancer	____ Kidney disease	____ Spina bifida
____ Cerebral palsy	____ Mental illness	____ Suicide
____ Cleft lips	____ Migraines	____ Other (specify): ________
____ Cleft palate	____ Multiple sclerosis	________________

____ Comments re: Family Health:____

____

CHILDHOOD/ADOLESCENT HISTORY

PREGNANCY/BIRTH

Child number ___ of ___ total children.

Did the mother use drugs or alcohol? ___Yes ___ No If Yes, type/amount: ______________

Describe any physical or emotional complications with the pregnancy and/or delivery: ____________

____

Describe any complications for the mother or the baby after the birth: ______________________

____

Developmental History

Did the child have any noted developmental delays? If so, please list and identify treatment, if applicable.

____

____

EDUCATION

Current school: ____________________ School phone number: ______________

Type of school: ___ Public ___ Private ___ Home schooled ___ Other (specify): ____________

Grade: ______________ School Counselor:______________

Does child have IEP or 6404? ___ Yes ___No If Yes, describe: ______________________________

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Has child ever been held back in school? ___ Yes ___ No If Yes, describe: ______________

What grades does the child usually receive in school? ______________________________

Have there been any recent changes in the child's grades? ____ Yes ____ No

If Yes, describe: ____

Has the child been tested psychologically? ___ Yes ___ No

If Yes, describe: ____

Check the descriptions that specifically relate to your child.

FEELINGS ABOUT SCHOOLWORK:

___ Anxious ___ Passive ___ Enthusiastic ___ Fearful
___ Eager ___ No expression ___ Bored ___ Rebellious

___ Other (describe): ____

APPROACH TO SCHOOLWORK:

___ Organized ___ Industrious ___ Responsible ___ Interested
___ Self-directed ___ No initiative ___ Refuses ___ Does only what is expected
___ Sloppy ___ Disorganized ___ Cooperative ___ Doesn't complete assignments

___ Other (describe): ____

PERFORMANCE IN SCHOOL (PARENT'S OPINION):

___ Satisfactory ___ Underachiever ___ Overachiever

___ Other (describe): ____

CHILD'S PEER RELATIONSHIPS:

___ Spontaneous ___ Follower ___ Leader ___ Difficulty making friends
___ Makes friends easily ___ Longtime friends ___ Shares easily
___ Other (describe): ____

Who handles responsibility for your child in the following areas?

School: ___ Mother ___ Father ___ Shared ___ Other (specify): ____________
Health: ___ Mother ___ Father ___ Shared ___ Other (specify): ____________
Problem behavior: ___ Mother ___ Father ___ Shared ___ Other (specify): ____________

LEISURE/RECREATIONAL

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

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Activity	How often now?	How often in the past?
________	________	________
________	________	________

MEDICAL/PHYSICAL HEALTH

Who is your child's Primary Care Manager/Provider (PCM/PCP)? ________

List any current health concerns: ________

____

List any recent health or physical changes: ________

____

Current prescribed medications	Dose	Dates	Purpose	Side effects
________	________	________	________	________
________	________	________	________	________
________	________	________	________	________
________	________	________	________	________

Name of prescribing physician/psychiatrist? ________

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
________	________	________	________	________
________	________	________	________	________
________	________	________	________	________
________	________	________	________	________

Has the child had all of their immunizations? ____ Yes ____ No

If no, please explain:

____

____

NUTRITION

Have there been any recent changes in the child's weight? ____ Yes ____ No

If so, please describe________

Have there been any recent changes in the child's appetite? ____ Yes ____ No

If so, please describe________

Do you have any other concerns related to the child's nutrition? ____ Yes ____ No

If so, please describe________

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CHEMICAL USE HISTORY

Does the child/adolescent use or have a problem with alcohol or drugs? ___ Yes ___ No

If Yes, describe:

____

____

COUNSELING/PRIOR TREATMENT HISTORY

Information about child/adolescent (past and present):

	Yes	No	When	Where	Reaction or overall experience
Counselling/Psychiatric treatment	___	___	___	___	___
Suicidal thoughts/attempts	___	___	___	___	___
Drug/alcohol treatment	___	___	___	___	___
Hospitalizations	___	___	___	___	___

BEHAVIORAL/EMOTIONAL

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

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

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___ Fatigue
___ Fearful
___ Frequent injuries
___ Poor appetite
___ Psychiatric problems
___ Quarrels
___ Other: ______________
____
____

Please describe any of the above (or other) concerns: ______________________________

____

How problem behaviors are generally handled? ______________________________

____

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

___ Yes ___ No If Yes, describe: ______________________________

____

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

____

____

____

Any additional information that would assist us in understanding current concerns or problems?

____

____

____

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

____

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

____

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

If Yes, explain: ______________________________

____

Signature of Parent/Guardian Filling Out Form: ______________________________

Date: ______________________________

RELATIONSHIP TO CHILD: ______________________________

Trinity Behavioral Health
Services

Phone: 931-919-2641 Fax: 931-919-2643

FOR STAFF USE

Therapist's comments: ____

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Therapist's signature/credentials: ______________________ Date: __/__/____

Supervisor's comments: ____

____

____

______________________ Physical exam: ___ Required ___ Not required

Supervisor's signature/credentials: ______________________ Date: __/__/____