Wellspring Christian Clinic Patient Registration

Patient Name: _____
(Last) (First) (Middle) (Preferred Name)

Address: _____
(Street) (City) (State) (Zip)

LISTING A NUMBER PERMITS WELLSPRING TO CALL THAT NUMBER AND LEAVE A MESSAGE

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Which number you would like us to call when making reminder calls? Home Work Cell

May we contact you via email? Y N Preferred email address: _____

Ethnicity: _____ Soc. Sec. #: _____ Date of Birth: _____ Age: _____ Sex: M F Marital Status: S M D W

Employer: _____ Occupation: _____ Full-Time Part-Time Student/School: _____

IF DEPENDENT CHILD – Are custodial parents Married Separated Divorced Other _____
Please list names, relationships, and phone numbers for **ALL** legal guardians
_____
_____
_____

IN CASE OF EMERGENCY PLEASE NOTIFY: _____
(Name) (Phone) (Relationship)

Primary Care Physician: _____
(Name) (Address) (Phone)

FINANCIALLY RESPONSIBLE PARTY/GUARANTOR INFORMATION

□ **CHECK IF SAME AS ABOVE**

Guarantor Name: _____ Date of Birth: _____ Home Phone: ( ) _____

Guarantor Address: _____
(Street) (City) (State) (Zip)

Guarantor Relationship to Patient: Self Spouse Mother Father Sibling Other Relative Friend Other

Employer: _____ Occupation: _____ Work Phone: ( ) _____ Soc. Sec. #: _____

Driver's License #: _____ Special Arrangements: _____

GUARANTOR AGREEMENT: I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Wellspring Christian Clinic. If the provider is contracted with the insurance company, I will be responsible for the co-pay, deductible, and non-covered services as determined by the insurance plan.

► GUARANTOR SIGNATURE: _____ DATE: _____

PATIENT RELEASE OF INFORMATION TO GUARANTOR/THIRD PARTY AGENCY: I authorize Wellspring Christian Clinic to release my financial information to my guarantor or a third party collection agency.

► PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

Please circle the name of the counselor/psychologist that you are seeing today:
Tammy Bond Jeremy Johnson Laura English Adam Calvert Kate Clark Kelley C. Jones Bonnie Roberts Al Saunders Ben Smith
Melea Stephens Leah Waller Melinda Higginbotham

How did you hear about Wellspring Christian Clinic?

□ Another Client of Wellspring
□ My Doctor
□ My Church
□ My Friend or Family Member
□ Radio Advertisement (WDJC)
□ Internet Website
□ I attended a seminar sponsored by Wellspring
□ My Insurance Company
□ Yellow Pages
□ Birmingham Christian Family Magazine
□ Other (_____)

CLIENT AGREEMENTS AND AUTHORIZATIONS

CHILD AND ADOLESCENT CONSENT FOR TREATMENT

Legal Guardian MUST sign if primary patient is under 18 years old.

Patient (please print): _____ Date of Birth: _____
(Last) (First) (Middle) (mm/dd/yyyy)

I certify that I am the: Father Mother Legal Guardian of the above child/adolescent
I certify that I do have the legal custody of the above named child/adolescent.
I, hereby, give my authorization and consent for the above named child/adolescent to receive outpatient assessment/therapy from:
_____

Name (please print): _____

Signature: _____ Date: _____

DIVORCE/LEGAL SEPARATION COLLECTION POLICY

Please sign if primary patient is under 18 years old and legal guardians are separated or divorced.

It is the policy of Wellspring Christian Clinic that the parent/guardian bringing a child/adolescent to our office for treatment is responsible for payment at the time services are rendered. You will be responsible for making prior payment arrangements with the child's/adolescent's other parent or responsible party. Wellspring Christian Clinic assumes no responsibility for collecting payment from the other parent or responsible party with whom you may have financial arrangements for your child's/adolescent's medical care.

I have read, understand and agree to the above policy:

Name (please print): _____

Signature: _____ Date: _____

ALL CLIENTS MUST READ AND SIGN

PRIVACY POLICY: I acknowledge having been offered Wellspring Christian Clinic's "Notice of Privacy Policies" and their "Client Rights Statement" (below and on following pages). My rights include the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record. These are explained in the Policy. My right to make a complaint and file a grievance has also been explained. I understand that I may revoke in writing my consent for release of my health care information except to the extent Wellspring Christian Clinic has already made disclosure with my prior consent. ► (_____)

CONSENT FOR TREATMENT: I hereby consent to the treatment provided by Wellspring Christian Clinic and its employees or designees. I authorize the services deemed necessary or advisable by my caregivers to address my needs. ► (_____)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION: I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of Wellspring Christian Clinic. I authorize Wellspring Christian Clinic to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Wellspring Christian Clinic may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. ► (_____)

► _____ _____ _____
Client or Authorized Person Signature Relationship Date

► _____ _____
Witness Signature Date

PRACTICE POLICIES AND SERVICE INFORMATION

Dear Patient:

Thank you for requesting an appointment with me at Wellspring Christian Clinic. I am pleased that you have chosen me as your clinician and I am committed to giving you the best care possible. I have enclosed several forms as well as a patient history questionnaire. All of this information is necessary for quality evaluation and management of treatment. Please complete everything included so that we can best complete in one session what otherwise might take two or three sessions. This saves you time and money as it allows me to move more quickly with an accurate assessment and treatment. I will be glad for you to keep a copy for future use with other doctors and clinicians if you so desire.

Wellspring Christian Clinic's office hours: Monday – Thursday 8:30 am – 4:30 pm & Friday 8:30 am – 12:30 pm.

To acquaint you further with the procedures and policies of this clinic, I am providing the following information:

- **Appointments:** I have appointments back to back throughout each day. I do my best to be punctual for your appointment unless an emergency interrupts. I ask that you be punctual as well. **If you are late for any reason, you will receive the remainder of your scheduled time. This is necessary so I can keep my following appointments at their scheduled time. If you need to cancel an appointment, a minimum advanced notice of one full workday is required so that we will have a chance to fill that slot.** You may leave a message with the office staff or on their voicemail. **We will charge you a full fee for late cancellations or failures to show.** Note: as a *courtesy*, we will call you the business day prior to your appointment to remind you of the time. However, we are sometimes unable to make this call or are unable to reach you. **YOU ARE STILL RESPONSIBLE FOR COMING TO YOUR APPOINTMENT OR CANCELLING 24 BUSINESS HOURS IN ADVANCE, even if you do not receive a call.**

- **Psychological Evaluations:** A psychological evaluation is a formal examination of mental health. Our psychological evaluations include clinical interviews, standardized measures of intellectual ability, achievement, personality, adaptive behavior, and social, emotional, and behavioral functioning, as well as clinical observation, and a review of relevant documentation. **Please understand this is a long process**. The clinical interview(s), administered tests, and filling out of various measures may take anywhere from two to five hours. In addition, the scoring, interpretation, and report write-up make also take anywhere from two to five hours. The psychological evaluation may ultimately result in diagnosis, recommendations, and/or feedback. The reports will be drafted and completed as soon as possible, and I will make the best possible effort not to go beyond **14** days from the date of the psychological evaluation. Included in the cost of the psychological evaluation will be one courtesy 30-minute feedback session in which I review the results of the psychological evaluation with you and/or the child. The feedback session will typically be scheduled upon the completion of the psychological evaluation.

- **Emergencies:** During office hours, let the office staff know that you have an emergency and the nature of the problem and one of them will try to contact me. After office hours, please leave me a voicemail. If you need after-hours emergency interventions, call 911 or go to your nearest local Emergency Room, where the staff can offer assessment and treatment.

- **Payment:** You are fully responsible for all services rendered. Full payment is expected at the time of service, unless other contractual agreements apply. Please make all checks payable to Wellspring Christian Clinic. As another payment option, we accept Visa or MasterCard. There will be a $25 fee for payments returned as non-sufficient or non-payable. All services rendered will be billed to you, your guarantor, or some contracted insurance plans by our office staff. If you have questions regarding your account balance, you may call 205-977-3003 to speak with an account representative. *Please Note*: Billing processes may include a monthly statement, phone call, or correspondence regarding the patient due portion of the account balance. Statements, phone numbers, and correspondence will be addressed regarding the patient/guarantor address or phone numbers listed on the Wellspring Registration Form. If any of these business office procedures present a problem for you or your treatment, please discuss your concern with your Wellspring Christian Clinic therapist or the office staff.

Payment (cont): I may be a provider with your insurance company. Please ask the office staff if you have any questions regarding this. They will give you a form with all of the information your insurance will need for you to file for reimbursement. Some managed care plans have specific providers for whom they will extend coverage, which means that services from providers not on these panels may or may not be eligible for reimbursement. The best way to find out if my services are eligible for reimbursement is to contact your insurance company directly, using the phone number provided on your insurance card. You may also contact your subscriber information booklet or the personnel office which manages your insurance.

- **Confidentiality:** Your patient records are the property of Wellspring Christian Clinic and shall be treated as confidential. To insure quality record maintenance and patient confidentiality, Wellspring Christian Clinic will conduct routine patient record audits. To comply with State and Federal Laws regarding patient confidentiality, your records will not be released without the properly executed written consent. Everything about your care will be held in strictest confidence. There are some circumstances in which we are required by law to break confidentiality.* If you choose to have your Wellspring Christian Clinic provider(s) keep a third party informed of your progress in counseling, it will be necessary to complete the following Release of Information form that will be kept on file.

  There are some circumstances in which I am required by law to break confidentiality. As a psychologist/therapist, I am both ethically and legally bound to keep in confidence any information you divulge to me. However, there are some exceptions to this confidentiality you should be aware of:
  1. If you are a danger to yourself or others in the immediate future, I will take the action necessary to protect everyone involved. This may include notifying persons or agencies such as family members, friends, intended victims, employers, and/or the police.
  2. If I see evidence of child abuse, elderly abuse, or abuse of a disabled person, or strongly suspect abuse in this regard is taking place, I am required by law to make a report to the Department of Human Resources in the county of residence for the child.
  3. If subpoenaed to provide information in a court of law, I will first assert psychologist (psychological trainee)-patient privilege. However, I can be ordered by a judge to report what you have said to me in confidence.

- **Termination:** Ending therapy may be initiated by you as the client, or as legal guardian of the client or myself as the therapist. In either event, a final session is strongly recommended to explore the ending process itself. This can be a useful conclusion to treatment. Referrals to other providers or other suggestions can be offered at that time.

- **Telephone Calls:** There is always someone you can reach to address your problems or concerns when needed. If you need to leave me a message on my voicemail, it will page me. I or the Wellspring Christian Clinic office staff will return your call.

- **Reports and Letters:** I have the right to bill for my time if you, another clinician, lawyer, insurance company, etc. request a letter or report. Payment is expected at the time of service. Unpaid balances will be billed to you or your guarantor from our office. Should you have any questions regarding your account balance, you may call our office at 205-977-3003. **Insurance companies may not reimburse for these fees.**

***Under law, I have the right to break confidentiality if there is suspected child abuse or intent to harm another or oneself.**

PLEASE SIGN BELOW TO INDICATE THAT YOU HAVE READ AND UNDERSTAND THE ABOVE NOTIFICATIONS AND THAT YOU ARE CONSENTING TO RECEIVE TREATMENT BY A WELLSPRING CHRISTIAN CLINIC PROVIDER:

► _____

Patient/Guardian Signature **Date**

I look forward to seeing you!

RELEASE OF INFORMATION:
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ SS#: _____

Home Phone: _____ Work Phone: _____

I, the understood patient or legal guardian, hereby authorize **verbal** (Yes / No) and/or **written** (Yes / No) information to be released **by**:

Wellspring Christian Clinic, 3104 Blue Lake Drive, Suite 100, Birmingham, AL 35243

To:

Name of Hospital/Clinician/ Attorney/Family Member/Friend/Pastor Phone Number Address

_____

_____

_____

_____

_____

Release information for the following purpose(s):
Treatment/Consultation Patient Request Billing/Claims Attorney Other: _____

Circle information to be released:
Psychiatric Evaluation Medication Record H&P/Lab Work Psychosocial Psychological Testing Treatment Planning Discharge Plan Progress Notes

- I understand that the information released may be (*Initial for release of the following information*) _____ Mental Health _____ Substance Abuse _____ HIV/AIDS information
- I understand that this authorization can be withdrawn by me in writing at any time. I cannot, however, take exception to actions that have taken place before I withdrew my consent.
- I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected. Wellspring Christian Clinic and its employees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I understand that the information which is being released is from records whose confidentiality is protected by State and Federal Law.

_____

Signature of Patient or Legal Representative (Description/Proof of authority for patient must be provided) Date

_____

Witness and Title Date

In the event of an emergency (e.g. intent to harm oneself or another), Federal Law allows Wellspring Christian Clinic to share sufficient information with necessary parties.

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

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

We respect client confidentiality and only release confidential information about you in accordance with state and federal law. This notice describes our policies related to the use of the records of your care generated by this clinic.
Privacy Contract:
If you have any questions about this policy or your rights contact the Clinic Director, Dr. Al Saunders, at 205-977-3003.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your confidential information with others beyond our clinic. This includes information to be used for:

Treatment We may use or disclose treatment information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside our clinics that we are consulting with or clinics to which you are being referred.
Payment With your written consent, information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment, insurance verification, or for billing purposes.
Healthcare Operations We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, or training our staff.
Information disclosed without your consent: Under state and federal law, information about you may be disclosed without your consent in the following circumstances:
Emergencies Sufficient information may be shared to address the immediate emergency you are facing.
Follow-up Appointment/Care We may be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We will leave appointment information on your answering machine unless you tell us not to.
As Required by Law This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and/or neglect such as child abuse or elder abuse.
Coroners We are required to disclose information about the circumstances of your death to a coroner who is investigating it.
Governmental Requirements We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure. Information may also need to be shared with the Food and Drug Administration related to adverse events or product defects. We are also required to share information, if requested, with the Department of Health and Human Services to determine our compliance with federal laws related to health care.
Criminal Activity or Danger to Others If any crime is committed on our premises or if a crime is committed off premises but against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement when we believe an immediate danger may occur to someone.

CLIENT RIGHTS STATEMENT

The following rights are extended to each client in the Day Program and the Outpatient Clinic services for all ages without reservation or limitation:

1. The right to confidentiality: The client has the right to every consideration of privacy concerning his or her medical care program, including HIV status and testing. All case discussion, consultation, communications, records, and medical information pertaining to his or her care will be treated as private and confidential;
2. The right to have impartial access to treatment regardless of age, psychological characteristics, sexual orientation, physical condition, race, religion, gender, ethnicity, marital status, HIV status, criminal record, or source of financial support;
3. The right to have personal dignity recognized and respected in the provision of all care and treatment;
4. The right to religious freedom;
5. The right to receive individualized treatment including the provision of an individualized treatment plan based upon information of all assessments, active participation in the development of the treatment plan by the client with periodic review of the plan by staff, and implementation and supervision of the plan by qualified professional staff;
6. The right to make decisions about the treatment plan prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and to be informed of the medical consequences of this action. In case of such refusal, the client is entitled to other appropriate care and services that Wellspring Christian Clinic provides or they may transfer to another facility;
7. The right to know the immediate and long-term financial implications of treatment choices, insofar as they are known;
8. The right to obtain from clinician, or other staff involved in direct care, relevant, current, and understandable information concerning diagnosis, treatment, and prognosis. The right to review the records pertaining to his/her treatment and to have the information explained or interpreted as necessary, except when restricted by law. If you request a copy of your records, we may charge you a reasonable fee for copying and mailing your record.

9. The right to know the identity of physicians, nurses, and others involved in their care, as well as when those involved are students, interns, residents, or other trainees;
10. The right to expect that, within its capacity and policies, the practice will make reasonable response to the request of a client for appropriate and medically indicated care and services. Wellspring Christian Clinic must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically appropriate and legally permissible, or when a client has so requested, a client may be transferred to another clinician's care. The clinician to whom the client is to be transferred must first have accepted the client for transfer. The client must also have the benefit of complete information and explanation concerning the need for, risks, benefits, and alternatives to such a transfer;
11. The right to ask and be informed of the existence of business relationships among the clinic, hospital, educational institutions, other health care providers, or payers that may influence the client's treatment and care;
12. The right to consent to or decline to participate in proposed research studies or human experimentation affecting care and treatment or requiring direct client involvement, and to have those studies fully explained prior to consent. A client who declines to participate in research or experimentation is entitled to the most effective care that the clinic can otherwise provide;
13. The right to receive prescribed services within the least restrictive but appropriate environment;
14. The right to assurance and protection of privacy and confidentiality of communication with treatment staff, and of material written in the client's individualized record;
15. The right to be presumed mentally competent unless a court has ruled otherwise;
16. The right to a clean and humane environment in which you are protected from harm, have privacy with regard to personal needs, and are treated with respect and dignity;
17. The right to be free from mistreatment, abuse, neglect, and exploitation;
18. The right to expect reasonable continuity of care when appropriate and to be informed by clinicians and other caregivers of available and realistic client care options;
19. The right to initiate a complaint or grievance, with the assurance of no retaliation, and to be informed of the appropriate grievance process;
20. The right to be informed that Wellspring Christian Clinic has the right to terminate care with a 30 day written notification given to the client with a listing of referrals for continuity of care;
21. The right to request an amendment to your record if you believe something in your record is incorrect or incomplete. Ask for the *Request to Amend Health Information* form.
22. Prior to admission to the Day Program, you have the right to be informed of all program rules and regulations concerning your conduct and course of treatment.
23. If you have a complaint about the services provided, you may file a grievance by doing the following:

Step One:	Discuss the issue with your therapist or doctor. He or she is there to help you with any issue that arises. It is never an inconvenience for them to assist you.
Step Two:	If the therapist or doctor is not able to adequately assist you with your concern and you have still not had your issues resolved, contact the Clinic Director, Dr. Al Saunders at 205-977-3003.

FILING OF COMPLAINTS AGAINST HIPAA-COVERED ENTITIES BELIEVED TO BE NON-COMPLIANT WITH HIPAA PRIVACY RULE

Complaints must be written to the Secretary of HHS, have occurred on or after April 14, 2003, and meet the following requirements:

- Be filed in writing, either on paper or electronically;
- Name the entity that is the subject of the complaint and describe the acts or omission believed to be in violation of the applicable requirements;
- Be filed within 180 days of when the complainant knew or should have known that the act or omission complained of occurred, unless this time limit is waived by the ORC for good cause is shown.

Electronic complaints should be sent to ORCComplaint@hhs.gov. Mailed complaints must be addressed to the ORC regional office that is responsible for matters relating to the Privacy Rule arising in the State or jurisdiction where the covered entity is located.

Region IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, or Tennessee)

Office for Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth Street SW
Atlanta, GA 30303-8909

WELLSPRING
CHRISTIAN CLINIC, INC.
3104 BLUE LAKE DRIVE, BIRMINGHAM, ALABAMA, 35243
P: 205.977.3003 F: 205.977.3939
• JEREMY JOHNSON, PSY.D., LICENSED PSYCHOLOGIST

BACKGROUND INFORMATION FORM

CONFIDENTIAL

Thank you for taking the time to fill out the Background Information Form. Please carefully read and accurately fill out all sections that apply to you, your child, and the family system. If completed and submitted at least 48 hours before your scheduled psychological or intake evaluation, this form will help streamline the assessment process and allow the clinician to provide the best possible service. Please ask or call if you have any questions.

Today's date: _____ Person filling out this form: _____ Relationship to the child: _____

Demographics:

Child Name: _____ DOB:_____ Age: _____
Ethnicity: _____ Sex (circle one): Male Female
Primary Language: _____

Presenting Problem(s):

Describe the primary reason(s) for why a psychological/intake evaluation is currently desired. Be specific as possible and try to describe actual thoughts, feelings, and/or behaviors your child is currently exhibiting (i.e. what you think is going on):

_____
_____
_____
_____
_____
_____
_____
_____

How long has this problem been a concern for you? _____
When was this problem first noticed? _____
What seems to help the problem? _____
What seems to make the problem worse? _____
Have you noticed changes in the child's abilities (circle one): Yes No
If yes, please describe:_____
_____
Have you noticed changes in the child's behavior (circle one): Yes No
If yes, please describe: _____
_____

Trauma History:

If the child has experienced a traumatic event, including child maltreatment, please specify below:

Type of Trauma	Age when happened	Age when ended	Briefly Describe
Physical Abuse			
Sexual Abuse			
Psychological Abuse			
Neglect			
Exposure to Domestic Violence			
Natural Disasters (i.e. tornadoes)			
Motor Vehicle Related			
Community Violence			
Immigration/Refugee-related			
Other			

Has the child lost anyone close to him/her? If so, please specify whom the child lost and describe the child AND family's reaction: _____
_____
_____
_____

Suicidal/Homicidal History:

Has the child attempted to commit suicide in the past (circle one): Yes No
If yes, how: _____
_____
_____

Is there a history of suicide in the nuclear or extended family (circle one): Yes No
If yes, please describe: _____
_____
_____

Has the child engaged in self-harm behaviors (i.e. cutting, burning, biting; circle one): Yes No
If yes, please describe: _____
_____
_____

Is the child currently homicidal or suicidal (circle one): Yes No

Family System

Family Structure

Biological Father's Full Name: _____ Age: _____
Ethnicity: _____ Biological Father currently has legal custody of the child (circle one): Yes No

Biological Father's Occupation: _____How Long Employed:_____
Biological Mother's Full Name_____ Age:
Ethnicity: _____ Biological Mother currently has legal custody of the child (circle one): Yes No
Biological Mother's Occupation: _____ How Long Employed:_____

Stepfather's Full Name: __ _____ Age: _____
Ethnicity: _____ Stepfather currently has legal custody of the child (circle one): Yes No
Stepfather's Occupation: _____ How Long Employed:_____
Stepmother's Full Name_____ Age:
Ethnicity: _____ Stepmother currently has legal custody of the child (circle one): Yes No
Stepmother's Mother's Occupation: _____ How Long Employed: _____

Please include information on all full, step, and half siblings. If possible list the siblings from oldest to youngest:
Sibling's Name_____ Age: _____ Circle one: Full/Half/Step
Sibling's Name_____ Age: _____ Circle one: Full/Half/Step
Sibling's Name_____ Age: _____ Circle one: Full/Half/Step
Sibling's Name_____ Age: _____ Circle one: Full/Half/Step
Sibling's Name_____ Age: _____ Circle one: Full/Half/Step
Sibling's Name_____ Age: _____ Circle one: Full/Half/Step
Sibling's Name_____ Age: _____ Circle one: Full/Half/Step
Sibling's Name_____ Age: _____ Circle one: Full/Half/Step
Sibling's Name_____ Age: _____ Circle one: Full/Half/Step
Sibling's Name_____ Age: _____ Circle one: Full/Half/Step

If other than the above, who currently has legal and physical custody of the siblings: _____
_____

Please include information on all others living in the parent's/stepparent's home:
Name_____ Age: _____
Name_____ Age: _____
Name_____ Age: _____
Name_____ Age: _____
Name_____ Age: _____
Name_____ Age: _____
Name_____ Age: _____
Name_____ Age: _____

Please include information on all other siblings and significant people living outside the home:
Name_____ Age: _____
Name_____ Age: _____
Name_____ Age: _____
Name_____ Age: _____

Relationship status of biological parents (circle one): Married Divorced Single
Please describe the biological family system in your own words: _____
_____
_____

Placement History:
Has the child or any of the child's siblings ever been removed from the legal and physical custody of their biological parents (i.e. DHR involvement; circle one)? Yes No

If so, please provide the details below (i.e. when removed, allegations, allegations substantiated, adjudication, case plan status, long-term placement plan, description of placements, placement disruptions, residential treatment, child's progress, etc.):

If the child has been displaced or otherwise removed from the custody of the biological parents, please provide information on the current legal guardians and current family system. This may include relative caregivers, foster parents, or residential staff:

Legal Guardian's Full Name: _____Age: _____
Ethnicity: _____ Relationship to the child: _____
Legal Guardian's Occupation: _____ How Long Employed: _____
Describe the Legal Guardians relationship to the child: _____
_____
_____

Legal Guardian's Full Name: _____ Age: _____
Ethnicity: _____ Relationship to the child: _____
Legal Guardian's Occupation: _____ How Long Employed: _____
Describe the Legal Guardians relationship to the child: _____
_____
_____

Please include information on all others living in legal guardian's the home:
Name_____ Age: _____
Name_____ Age: _____
Name_____ Age: _____
Name_____ Age: _____
Name_____ Age: _____
Name_____ Age: _____
Name_____ Age: _____
Name_____ Age: _____

<u>Parental Divorce or Separation:</u>

Are the biological parents divorced or separated (circle one): Yes No
If so, what month and year: _____

What are the current custody arrangements: _____
_____
_____
_____
_____
_____

What are the current visitation arrangements: _____
_____
_____
_____
_____

Describe the current relationship between the divorced or separated parents: _____
_____
_____
_____
_____

How has the child experienced the divorce or separation: _____
_____
_____
_____
_____

Family Stress: (circle all that apply): Financial Work-Related Transition-related Medical Family-related

Outside of the family system, who does the child and/or the family rely on for support (i.e. a teacher, pastor, guidance counselor, etc.): _____
_____
_____

Medical History

Development:

Did the mother utilize appropriate pre-natal care (circle one): Yes No
Did the mother use alcohol, tobacco, or any illicit substances during the pregnancy and post-natal period (circle one): Yes No
If so, please specify: _____
_____
_____
_____
_____
_____

Were there any birth complications (prenatal, perinatal, or postnatal)?
If so, please specify: _____
_____
_____
_____
_____
_____

How old (years-months) when the child began walking: _____
How old (years-months) when the child began talking: _____
How old (years-months) when the child finished toilet training: _____
Does the child have any history of speech/language delays, occupational services, or motor difficulties?
If so, please specify: _____
_____
_____

Is there any familial history related to genetic abnormalities, intellectual disabilities, or neurological functioning:
_____
_____
_____
_____

Is there any current problems related to genetic abnormalities, intellectual disabilities, or neurological functioning:
_____
_____
_____
_____

Medicinal Care:

Current Pediatrician: _____ Phone Number: _____

Current Psychiatrist: _____ Phone Number: _____

Please describe any current medical problems: _____
_____
_____
_____

Current medications:

Name:	**Dosage:**	**Taken For:**	**Taken Since:**	**Side Effects Experienced:**	**Is this medication effective?**

Previous Medications:

Name:	**Dosage:**	**Taken For:**	**Taken Since:**	**Side Effects Experienced:**	**Is this medication effective?**

Please describe any allergic reactions to medications:

_____

_____

Please describe the parents'/legal guardians' beliefs/preferences in regard to medications: _____

_____

_____

_____

If the biological parents are taking any psychotropic (mental-health-related) medications please describe:

_____

_____

_____

_____

General Medical/Neuropsychological Information:

Has the child experienced any of the following (circle all that apply):

Surgeries Hospitalizations (for wanting to hurt themselves or others)

Head Trauma Bedwetting Seizures Vision/Hearing Problems

If yes, describe the situation/symptoms in detail and include any treatment: _____

_____

_____

_____

_____

Any troubles related to the child's sleep, eating, or exercise habits (i.e. insomnia, nightmares, night terrors, sleep-walking, obesity, or binge-eating)(circle one)? Yes No

If so, please describe in detail and include any treatment:_____

_____

_____

_____

_____

_____

Are the child's blood work and immunizations up-to-date (circle one): Yes No

Has the child had a vision, health, and dental check-up within the last year (circle one)? Yes No

If not, please specify: _____

_____

_____

_____

Family Medical/Psychiatric History:

Please describe the child's family medical history: _____
_____
_____
_____

Please describe the child's family psychiatric history: _____
_____
_____
_____

Legal History

Child Legal Activity:

Please describe all previous arrests/charges/convictions for the child as well as the consequences administered by the court:_____
_____
_____
_____

Family Legal History:

Please describe all previous arrests/charges/convictions for the parents/caregivers as well as the consequences administered by the court: _____
_____
_____
_____
_____
_____
_____

Social History

Interpersonal functioning:

Does the child struggle socially in regard to building and maintaining friendships?
If yes, please describe:_____
_____
_____
_____
_____
_____

Does the child struggle socially in regard to aggression, irritability, or withdrawal?
If yes, please describe: _____
_____
_____

Previous Testing and Treatment History

Assessment History:

Has the child been administered any of the following: psychological evaluation, psychosexual evaluation, intake evaluation, court-ordered evaluation, psychoeducational evaluation, or any such assessment related to their mental health?

If so, please describe: _____

_____

_____

Treatment History:

Has the child ever participated in any therapy or treatment?

If so, please describe: _____

_____

_____

_____

_____

*****PLEASE BE SURE TO BRING IN ANY AND ALL COPIES OF THE ABOVE DOCUMENTS SO THAT THE BEST POSSIBLE SERVICE CAN BE PROVIDED*****

Substance Use History:

Please list all *prior* alcohol, illicit drugs, or tobacco the child has used:

Name of substance:	First Use:	Last Use:	Able to Quit (yes or no):	Side Effects Experienced:	Were there problems associated with the use of this substance?

Please list all *current* alcohol, illicit drugs, or tobacco the child has used:

Name of substance:	First Use:	Last Use:	Able to Quit (Yes or No):	Side Effects Experienced:	Were there problems associated with the use of this substance?

Please list all prior and current alcohol, illicit drugs, or tobacco use related to the *parents/caregivers*:

Name of substance:	First Use:	Last Use:	Attempted to Quit (Yes or No):	Side Effects Experienced:	Were there problems associated with the use of this substance?

Academic History

Current Issues:

Current School: _____ Grade: _____
Is this an alternative placement school program (circle one): Yes No
Teacher's/Guidance Counselor's name: _____ Phone Number: _____

Please list the child's current classes and corresponding grades:

Classes:	**Grades:**

Please describe any academic difficulties the child is having in school (please include any learning disabilities or learning issues assumed or suspected):

_____
_____
_____
_____
_____

Please describe any behavioral difficulties the child is having in school:

_____
_____
_____

What interventions, protocols, or education plans has the school put in place for the previous two questions (academic and behavioral issues at school):

_____
_____
_____
_____
_____
_____

Does the child have an Individual Education Plan on file at the school (circle one): Yes No
If so, please explain what allowances/interventions the child is able to utilize: _____
_____
_____
_____
_____

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