

PROVIDER _____ LOCATION _____

PLEASE FILL OUT ALL INFORMATION IN FULL

CLIENT NAME _____ SS# _____

PARENT/LEGAL GUARDIAN _____ SS# _____

PT. DATE OF BIRTH _____ AGE _____ SCHOOL _____ GRADE _____

ADDRESS _____ APT NO. _____ CITY _____ ZIP _____

HM PHONE _____ WK PHONE _____ REFERRING DR. _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME _____ PHONE: HM _____ WK _____

PLEASE BRIEFLY DESCRIBE THE DIFFICULTIES FOR WHICH YOU ARE SEEKING TREATMENT:

PLEASE LIST OTHER FAMILY MEMBERS IN THE HOME AND THEIR RELATIONSHIP TO THE CLIENT:

PLEASE LIST ANY SIGNIFICANT MEDICAL HISTORY AND CURRENT CONDITIONS: _____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? WHO PRESCRIBED THEM? _____

HAVE YOU EVER RECEIVED COUNSELING OR PSYCHOTHERAPY BEFORE? IF SO, PLEASE DESCRIBE
CONDITION AND OUTCOME. _____

WHO WAS THE TREATING PROFESSIONAL? _____

MAY WE REQUEST THOSE RECORDS? (If so, please sign the Authorization for Release of Information) _____

MAY WE LEAVE MESSAGES AT HOME? Y___ N___ MAY WE LEAVE MESSAGES AT WORK? Y___ N___

**YOU HAVE A RIGHT TO REQUEST THAT CONFIDENTIAL CORRESPONDENCE BE MAILED TO AN ALTERNATE ADDRESS.
IF THIS IS YOUR WISH, PLEASE PROVIDE THE ALTERNATE INFORMATION.**

It is our policy to send a copy of your evaluation to the referring doctor and to the client/legal guardian. Please initial here to indicate your agreement _____. If you do not wish your evaluation to be mailed either to your home or to your doctor, please provide alternate instructions (example: you may pick up the report at the office). **Note to Medicaid clients:** We are required by Alabama Medicaid to send your evaluation results to the referring doctor. There is no charge for providing your evaluation results as listed above. Additional copies will be charged a fee of \$1.00 per page, minimum charge \$5.00.

PROVIDER _____ LOCATION _____

If you do not wish for claims to be filed to your insurance company, please cross out the insurance information sections in ink and initial here: _____. Any charges incurred will be due in full at the time of service. We accept cash or checks, but are unable to process credit card payments.

PRIMARY INSURANCE:

COMPANY NAME _____ SUBSCRIBER _____
SUBSCRIBER'S DATE OF BIRTH _____ RELATIONSHIP TO CLIENT _____
CONTRACT/ID # _____ GROUP # _____
EFFECTIVE DATE _____ IF BC/BS: BS PLAN # _____ BC PLAN # _____

SECONDARY INSURANCE:

COMPANY NAME _____ SUBSCRIBER _____
SUBSCRIBER'S DATE OF BIRTH _____ RELATIONSHIP TO CLIENT _____
CONTRACT/ID # _____ GROUP # _____
EFFECTIVE DATE _____ IF BC/BS: BS PLAN # _____ BC PLAN # _____

TERTIARY INSURANCE:

COMPANY NAME _____ SUBSCRIBER _____
SUBSCRIBER'S DATE OF BIRTH _____ RELATIONSHIP TO CLIENT _____
CONTRACT/ID # _____ GROUP # _____
EFFECTIVE DATE _____ IF BC/BS: BS PLAN # _____ BC PLAN # _____

Our office will file claims to your insurance company as a courtesy to you. In the event of discontinuing this service, you will be notified in writing with an explanation of our decision. Any services rendered after the date of notice will be due in full at the time of service. Deductibles, co-pays, and services denied by insurance are due at the time of service, or upon receipt of an account statement. Deductibles and co-pays are the responsibility of the guardian who brings the client for treatment. We will be happy to provide you with a copy of the bill and receipt of payment if you are entitled to reimbursement by a third party. Failure to pay these charges in a timely manner may result in your account being turned over to a collection agency or for legal action. Any additional charges incurred in the collection of the account will also be your responsibility.

Your signature below will serve as your authorized signature for the release of protected health information required by your insurance company when filing both paper HCFA-1500 claim forms and electronic claim forms. If you have any questions concerning this release of information, please ask to speak to the office manager.

SIGNATURE _____ DATE _____

I certify that the above information is true and correct to the best of my knowledge. I understand that by law, certain protected health information may be released for the purposes of continuity of treatment, referral to another professional, and/or to gain payment from an insurance company. Alabama law provides that clients 14 years old or older have a right to keep mental health treatment information confidential from legal guardians. Please discuss this with the treating professional if you have any questions or concerns.

SIGNATURE _____ DATE _____

PARENT/LEGAL GUARDIAN _____ DATE _____

WITNESS _____ DATE _____

Keith L. Ellis, MS, LMFT



Family Counseling Center LLC

1275 James Street
Enterprise, AL 3633
Phone: 334-308-2292
FAX: 1-866-614-3263

Welcome to the Family Counseling Center. I appreciate your giving me the opportunity to assist you. This should answer some questions that clients often ask about my therapy practice. It is important to me that you know how we will work together. I believe our work will be most helpful to you when you have a clear idea of what we are trying to do. This **Orientation to Therapy** talks about the following in a general way:

- The risks and benefits of therapy.
- How much services cost, and how I handle money matters
- The goals of therapy are, and what my methods of treatment are like
- Other areas of our relationship

After you read this orientation, we can discuss, in person, how these issues apply to your own situation. You may keep a copy of this agreement and refer to it later. Please read all of it and mark any parts that are not clear to you. Write down any questions you think of; and we will discuss them. When you have read and fully understood this document, I will ask you to sign it and I will keep a copy as our contract. This Standard of Care applies to therapy done by Keith Ellis and all therapist, students and/or interns under his supervision.

I use an integrated approach to therapy. It combines individual and family system psychotherapy insights to offer clients the best possible care.

Mission:

- To help each person we serve to achieve a more satisfying quality of life.
- To provide high quality services to prevent and/or reduce the negative effects of dysfunctional family interactions.
- To promote wellness for each member of the family.

Credentials

- Licenced Marriage and Family Therapist
- B.S.W. (Social Work)
- M.S. Counseling - Marriage and Family Therapy
- Clinical Member AAMFT

Services: Marriage and Family Therapist treat individuals, couples and families.

Time: Individuals, couples, and families can expect each session to last fifty (50) minutes from the time specified. Groups will meet for ninety (90) minutes to 2 hrs. once each week.

Accessibility: Consultation is available through my office at (334) 308-2292 Monday through Friday from 8:30 am to 4:30 pm. Please note that these consultations are primarily for the purpose of arranging or changing an appointment. Only on rare occasions will I conduct therapy via telephone. Such therapy is billable at the applicable rate. I will not interrupt ongoing sessions with other clients to answer phone calls or pages. My **emergency pager number is** (334) 406-1200.

Consultations: Therapists may, at the request of the client, contact others on behalf of a client. If the client is under the care of a Psychiatrist the client must provided a current signed release for consultation with the Psychiatrist. You will be required to sign appropriate release for any such consultation.

Court Appearance: Court appearances will be billed at a rate of \$ 150 per hour from the time I leave the office until I return. This includes travel and waiting time. There will also be a milage charge of 32.50 per mile. The party who issues the subpoena accepts responsibility for payment of such charges. Normally, I do not make court appearances. All parties involved in the therapy must provide a signed release to divulge any confidential communication.

Limitations: Appointments will be set at mutually convenient times. They will not normally be available on weekends or Federal holidays.

Confidentiality: All clients have the right to expect confidentiality at all times. Records will be kept in a coded form. References to a client or his/her family will be by code numbers or letters. The standard of practice for family therapists is to consider the "client" as the entire family system. At a minimum, this includes all members living under the same roof. Therefore, before any information can be given to anyone, a signed release from all members of the family system (who are a part of the therapy) is necessary. The following exceptions to confidentiality exist: Reporting Child Abuse. Those under whose legal age parents' rights are in place. Court Orders, and court orders. Also records may be used to defend any action were brought against the therapist.

Financial Policy: Fees are paid to Family Counseling Center LLC.

Fees are:

\$80.00 per hour (45-50 minutes sessions)

\$ 45.00 per half hour (25 -30 minutes sessions.)

\$ 50.00 per half hour interactive therapy

\$ 120 per (Intake & 90 minutes sessions)

(The cost of testing is additional to the hourly rate and is the responsibility of the client.)

Payment is expected at the time of treatment. If special payment considerations are needed please discuss this with me as we begin therapy. Please let me know if there are ever any questions regarding your bill.

Insurance Information: Some insurance will pay for counseling others will not. Regardless of insurance payment, the client is ultimately responsible for payment of services.

Diagnosis: The standard of practice for marriage and family therapists is to diagnose each family as either FUNCTIONAL or DYSFUNCTIONAL. A diagnosis under the standards of DSM-IV may, when warranted, be given one or more individuals within a client family.

Referral: As per the AAMFT Code of Ethics, a therapist must withdraw from the contract any time she/he feels that the interaction is no longer beneficial to the client. If this happens, a referral to another therapist in or near the client's community will be suggested. The client is free to choose this or another therapist.

Withdrawal from therapy: The client may terminate the contract at any time. However, clients should discuss their decision to terminate with the therapist rather than simply "quitting". If the client elects to simply quit, then missing two (2) successive scheduled appointments, or failing to pay for two successive appointments, will be considered withdrawal from the contract.

Records: The following records are maintained: Attendance, client contact information, test profile(s), and coded process & assessment notes. Typically records are maintained for seven Years or in accordance with existing laws.

Duty to Warn: We will abide by the laws of the State of Alabama in regards to the duty of the therapist to warn whenever there is a reasonable probability of willful harm to self or others. Duty to preserve life takes precedence over duty to maintain confidentiality.

Mandatory Reporter of Child Abuse: Under state law I am a mandatory reporter of child abuse. If such should come up it must be reported to the state and/or law enforcement for investigation.

The Risks of Counseling: The greatest risk of counseling is that it may not by itself resolve your problem or concern. Your growth may be in unintended, or even undesired, directions. For that reason we do our best to assess progress on a week-by-week basis.

Enterprise Behavioral Health Services: As you know, I work with a group of independent mental health professionals under the name **Enterprise Behavioral Health Services**. This group is an association of independently practicing professionals which shares certain expenses and administrative functions. While the members share a name and office space, I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained and no member of the group can have access to them without your specific, written permission. I will be happy to address any questions or concerns you may have.

My signature acknowledges receipt of this Standard of Care

Date

Family Counseling Center LLC

1275 James Drive

Enterprise Alabama 36330

Phone 334-308-2292 FAX 1-866-614-3263

Personal 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 legal custody? _____

Were 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 ___ Step-parent ___ Adoptive parent ___ Foster home ___ Other (specify): _____

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

___ 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 Step-parent Adoptive parent Foster home Other (specify): _____

Is 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

Names of Siblings	Age	Gender	Lives		Quality of relationship		
					with the client		
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home	<input type="checkbox"/> away	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home	<input type="checkbox"/> away	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home	<input type="checkbox"/> away	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> home	<input type="checkbox"/> away	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
Others living in the household			Relationship (e.g., cousin, foster child)				
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	_____	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	_____	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	_____	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	_____	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good

Comments: _____

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:

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Deafness | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glandular problems | <input type="checkbox"/> Perceptual motor disorder |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Heart diseases | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Spinal Bifida |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Cleft lips | <input type="checkbox"/> Migraines | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Cleft palate | <input type="checkbox"/> Multiple sclerosis | _____ |

Comments re: Family Health: _____

Childhood/Adolescent History

Pregnancy/Birth

Has the child's mother had any occurrences of miscarriages or stillborns? ___ Yes ___ No

If Yes, describe: _____

Was the pregnancy with child planned? ___ Yes ___ No Length of pregnancy: _____

Mother's age at child's birth: _____ Father's age at child's birth: _____

Child number ___ of ___ total children.

How many pounds did the mother gain during the pregnancy? _____

While pregnant did the mother smoke? ___ Yes ___ No If Yes, what amount: _____

Did the mother use drugs of alcohol? ___ Yes ___ No If Yes, type/amount: _____

While pregnant, did the mother have any medical or emotional difficulties? (e.g., surgery, hypertension, medication) ___ Yes ___ No

If Yes, describe: _____

Length of labor: _____ Induced: ___ Yes ___ No Caesarean? ___ Yes ___ No

Baby's birth weight: _____ Baby's birth length: _____

Describe any physical or emotional complications with the delivery: _____

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

Length of hospitalization: Mother: _____ Baby: _____

Infancy/Toddlerhood Check all which apply:

<input type="checkbox"/> Breast fed	<input type="checkbox"/> Milk allergies	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Bottle fed	<input type="checkbox"/> Rashes	<input type="checkbox"/> Colic	<input type="checkbox"/> Constipation
<input type="checkbox"/> Not cuddly	<input type="checkbox"/> Cried often	<input type="checkbox"/> Rarely cried	<input type="checkbox"/> Overactive
<input type="checkbox"/> Resisted solid food	<input type="checkbox"/> Trouble sleeping	<input type="checkbox"/> Irritable when awakened	<input type="checkbox"/> Lethargic

Developmental History Please note the age at which the following behaviors took place:

Sat alone: _____ Dressed self: _____

Took 1st steps: _____ Tied shoelaces: _____

Spoke words: _____ Rode two-wheeled bike: _____

Spoke sentences: _____ Toilet trained: _____

Weaned: _____ Dry during day: _____

Fed self: _____ Dry during night: _____

Compared with others in the family, child's development was: ___ slow ___ average ___ fast

Age for following developments (fill in where applicable)

Began puberty: _____ Menstruation: _____

Voice change: _____ Convulsions: _____

Breast development: _____ Injuries or hospitalization: _____

Issues that affected child's development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.)

Education

Current school: _____ School phone number: _____

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

Grade: _____ Teacher: _____ School Counselor: _____

In special education? Yes No If Yes, describe: _____

In gifted program? Yes No If Yes, describe: _____

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

Which subjects does the child enjoy in school? _____

Which subjects does the child dislike in school? _____

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 which specifically relate to your child.

Feelings about School Work:

Anxious Passive Enthusiastic Fearful
 Eager No expression Bored Rebellious
 Other (describe): _____

Approach to School Work:

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 Long-time 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): _____

If the child is involved in a vocational program or works a job, please fill in the following:

What is the child's attitude toward work? Poor Average Good Excellent

Current employer: _____ Position: _____ Hours per week: _____

How have the child's grades in school been affected since working? Lower Same Higher

How many previous jobs or placements has the child had? _____

Usual length of employment: _____ Usual reason for leaving: _____

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.)

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

Medical/Physical Health

- | | | |
|--|---|---|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Hayfever | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hives | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Influenza | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Lead poisoning | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Congenital problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Severe colds |
| <input type="checkbox"/> Croup | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Severe head injury |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Thyroid disorders |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mumps | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Ear aches | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Wearing glasses |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Other skin rashes | <input type="checkbox"/> Other |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Paralysis | _____ |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Pleurisy | _____ |

List any current health concerns: _____

List any recent health or physical changes: _____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten			
Breakfast	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High
Lunch	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High
Dinner	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High
Snacks	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High

Comments: _____

Most recent examinations

Type of examination	Date of most recent visit	Results
Physical examination	_____	_____
Dental examination	_____	_____
Vision examination	_____	_____
Hearing examination	_____	_____

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

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

Immunization record (check immunizations the child/adolescent has received):

	DPT	Polio		
2 months	___	___	15 months	___ MMR (Measles, Mumps, Rubella)
4 months	___	___	24 months	___ HBPV (Hib)
6 months	___	___	Prior to school	___ HepB
18 months	___	___		
4-5 years	___	___		

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
Counseling/Psychiatric treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____

Behavioral/Emotional

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

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

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

How are problem behaviors generally handled? _____

What are the family's favorite activities? _____

What does the child/adolescent do with unstructured time? _____

Has the child/adolescent experienced death? (friends, family pets, other) ___ Yes ___ No

At what age? _____ If Yes, describe the child's/adolescent's reaction: _____

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: _____

For Staff Use

Therapist's comments: _____

Therapist's signature/credentials: _____ Date: ___/___/___

Supervisor's comments: _____

_____ Physical exam: _____ Required ___ Not required

Supervisor's signature/credentials: _____ Date: ___/___/___

(Certifies case assignment, level of care and need for exam)