Welcome to
Children’s Behavioral Health

Thank you for choosing Behavioral Health. We want you to feel comfortable here. Since many individuals are unaccustomed to a situation in which their feelings and “problems” are the focus of attention, communication may at times feel awkward. There is a difference between conversation and therapy. If at any time you have questions about the course of treatment, feel free to discuss them with your provider. Please ask questions until you feel you understand.

Privacy and Confidentiality
Attached is a document entitled “Joint Notice of Privacy Practices,” which applies to all entities of Children’s Healthcare Services. Please be aware that the psychological records of Behavioral Health are kept separate from the medical records of the hospital, and thus are afforded additional assurance of privacy and confidentiality.

All psychotherapy records, as well as discussions that occur during appointments, are confidential. Such information is released to outside sources only upon consent of a signed “Authorization to Release Health Information” form. You may revoke this permission in writing at any time.

Confidential information may be released without consent as required by law. For example, the law requires a provider to release information if the provider feels that a patient is in a dangerous or abusive situation or thinks a client might harm herself/himself or others. There may be other situations in which the law compels the release of information.

Appointments
Efforts will be made to make appointments at a time that is convenient to you. It is important that treatment continues on a regular basis. When cancellations occur, please attempt to reschedule the appointment at the time of the cancellation or as soon as possible. You may be charged for appointments that are cancelled less than 24 hours in advance. In order that we may serve others who desire treatment, repeatedly missing appointments without notification may require discontinuation of services.

Payment
It is our policy that the client pays wholly or in part for services rendered before leaving the office. Your provider must discuss any variation from this policy with the director. Checks should be made payable to Children’s Hospital. Debit cards, MasterCard, Discover, American Express and VISA are also accepted.

Emergencies/Phone Calls
We encourage you to discuss any problems or concerns during your regular appointments. If you need to talk directly to your provider between appointments, please understand that we will return calls as our schedules permit. It is often helpful to relay messages through the office staff when possible.

Honesty and Integrity
Again, thank you for choosing Children’s Behavioral Health. Our goal is to assist you in dealing effectively with problems you are having while respecting your dignity, privacy and confidentiality. We are embarking on a cooperative effort, which can succeed only if we are open and honest with each other. We hope you will be comfortable with us and benefit from the experience.
Pretreatment Questionnaire-Child/Youth

Patient Name ___________________________ Birth date ________ Today’s date ________

Form Completed by ________________________ Parent ________ Legal Guardian
Referred by ________________________________

Primary concern(s) for which treatment is sought:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Parents are: ____ married ____ divorced ____ separated ____ other: ____________________

How well is your child doing in the following areas:

<table>
<thead>
<tr>
<th>Area</th>
<th>Poor</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Excellent</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grades in school?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Behaving in school?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Behaving at home?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Getting along with family?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Getting along with peers?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Overall level of Functioning</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

Individuals living in your home: (*Including Adults)

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>_________________________</td>
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<td>_________________________</td>
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</tr>
</tbody>
</table>

1
**Individuals living in your home part-time:**

Name ___________________ Age _______ Relationship ____________________

Name ___________________ Age _______ Relationship ____________________

**Developmental history:**

Complications at birth or in early childhood? __ yes __ no  If yes, please explain:

__________________________________________________________________________

Approximate age walked _______ Approximate age talked _______

Any known developmental delays? ____________________________________________

__________________________________________________________________________

**Medical Issues:**

Date of your child’s last physical exam _______________ Physician’s Name: __________

At any time has your child had the following:

1. Asthma  
   - Never  
   - Past  
   - Present

2. Allergies  
   - Never  
   - Past  
   - Present

   Type of allergies: __________________________________________________________

3. Diabetes, arthritis, or other chronic illnesses  
   - Never  
   - Past  
   - Present

4. Epilepsy or seizure disorder  
   - Never  
   - Past  
   - Present

5. Surgery  
   - Never  
   - Past  
   - Present

6. Lengthy hospitalization  
   - Never  
   - Past  
   - Present

7. Speech/language problems  
   - Never  
   - Past  
   - Present

8. Hearing difficulties  
   - Never  
   - Past  
   - Present

9. Eye/vision problems  
   - Never  
   - Past  
   - Present

10. Fine motor/handwriting problems  
    - Never  
    - Past  
    - Present

11. Gross motor difficulties, clumsiness  
    - Never  
    - Past  
    - Present

12. Appetite problems (overeating or under eating)  
    - Never  
    - Past  
    - Present

13. Sleep problems (falling asleep, staying asleep)  
    - Never  
    - Past  
    - Present

14. Soiling problems  
    - Never  
    - Past  
    - Present

15. Wetting problems  
    - Never  
    - Past  
    - Present

16. Serious injuries: __________________________________________________________

17. Explain any hospitalizations or surgeries: __________________________________

__________________________________________________________________________

Immunizations current: __ yes __ no  If no, explain: __________________________________

__________________________________________________________________________

__________________________________________________________________________
**Medications (prescribed and over-the-counter):**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Prescribing physician</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

**Previous mental health treatment:**

<table>
<thead>
<tr>
<th>Mo/Yr</th>
<th>Provider</th>
<th>Treatment</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**Family History:**

Please indicate whether any of your child’s blood relatives have experienced any of the following:

<table>
<thead>
<tr>
<th>Anxiety</th>
<th>□ none</th>
<th>□ yes</th>
<th>Who?</th>
<th>Treated?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>□ none</td>
<td>□ yes</td>
<td>Who?</td>
<td>Treated?</td>
</tr>
<tr>
<td>ADHD</td>
<td>□ none</td>
<td>□ yes</td>
<td>Who?</td>
<td>Treated?</td>
</tr>
<tr>
<td>Behavior Problems</td>
<td>□ none</td>
<td>□ yes</td>
<td>Who?</td>
<td>Treated?</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>□ none</td>
<td>□ yes</td>
<td>Who?</td>
<td>Treated?</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>□ none</td>
<td>□ yes</td>
<td>Who?</td>
<td>Treated?</td>
</tr>
<tr>
<td>Suicide</td>
<td>□ none</td>
<td>□ yes</td>
<td>Who?</td>
<td>Treated?</td>
</tr>
<tr>
<td>Abuse</td>
<td>□ none</td>
<td>□ yes</td>
<td>Who?</td>
<td>Treated?</td>
</tr>
</tbody>
</table>

**Academic/Educational history:**

<table>
<thead>
<tr>
<th>Current school</th>
<th>Current Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Special education placement? □ yes □ no If yes, in what area? __________________________

Has the school performed psychological testing? □ yes □ no □ don’t know

Is there an IEP (Individual Education Plan)? □ yes □ no □ don’t know

Has your child’s teacher expressed any concerns about your child’s social, emotional, behavioral, or academic functioning? If yes, please explain

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
Substance Use:
Tobacco use: __None __ Suspected __ Known to use currently
Type: ___________________________ Amount: ___________ How often: ______
Drug use: __None __ Suspected __ Known to use currently __ Recovering
Type: ___________________________ Amount: ___________ How often: ______
Alcohol: __ None __ Suspected __ Known to use currently __ Recovering
Type: ___________________________ Amount: ___________ How often: ______
Caffeine use: __ None __ Amount and Frequency: ______________________________

Child’s Interests/Activities:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Child’s Strengths:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Current Legal Concerns: _____ yes _____ no  If yes, explain: ______________________
________________________________________________________________________

Religious/Spiritual Affiliation(s): __________________________  ____ none ____ prefer not to answer

Is there anything you would like to discuss with the provider without your child present? If so, explain:
________________________________________________________________________
________________________________________________________________________

Parent/Legal Guardian Signature: ____________________________________________ Date: __________

________________________________________________________________________
Reviewing Provider Date

Supervising Provider (if applicable) Date
Behavioral Health Care Treatment Agreement

The patient named above ("the Patient") will receive behavioral health care at Children’s Behavioral Health ("Children’s”), a department of Children’s Hospital & Medical Center. In my capacity as the parent/legal guardian/legally authorized representative of the Patient (or as an adult patient or emancipated minor patient), I understand and agree to the following:

a. I understand that the Patient’s trust in his/her behavioral health care providers ("Providers") is essential to the therapeutic process. To further that trusting relationship, I agree that:
   1. Discussions between Children’s Providers and the Patient may be held confidential from me unless the Patient is deemed to be at risk of harming him/herself or others;
   2. I will not request that any of the Patient’s treatment records be released to my attorney; and
   3. My attorney will not request any Children’s Providers’ testimony or deposition in the event of a legal dispute.

b. I understand that Children’s Providers do not perform custody evaluations, so should custody or placement of the Patient ever be an issue, I should seek an independent custody evaluation from a psychologist who specializes in forensic evaluation.

c. I understand that the Patient’s other parent (unless his/her parental rights have been terminated or otherwise limited by law) and/or another legal guardian or legally authorized representative of the Patient may (1) be given the same information and recommendations regarding the Patient that I am given and (2) make an appointment to review the Patient’s treatment records to address any questions or concerns that might arise.

d. I understand that the Patient’s Providers must report any evidence of possible child abuse or neglect to the appropriate authorities.

Signature of Parent with Legal Custody, Legal Guardian, Adult Patient or Emancipated Minor Patient, or Other Legally Authorized Representative of Patient  

Date

Print Name  

Relationship to Patient

Signature of Provider  

Print Name  

Date
Electronic-Mail Awareness Consent Form

Electronic Mail communications involving and/or containing information about the patients care will be maintained in the patient’s medical record (chart). This would apply to communication from the patient, parent/guardian or treatment provider. In addition please be aware that our computer system does not permit an out of office notice to be posted for non internal users. We acknowledge that emailing the treatment provider directly is not a secure form of communication, and we agree and accept the use of direct email communication with the treatment provider. Finally, email should not be used for emergency communication.

I have read the above statement and understand and accept the contents.

_________________________  __________________________
Parent/Guardian Signature  Date

_________________________  __________________________
Patient Signature (19 or older)  Date

_________________________
Patient Name (Print)
CATEGORIES FOR CONSENTING TO TREATMENT

Please (✓) check which one applies:

___ Biological parents are married; each parent can consent to treatment of child

___ Adoptive parents are married; each parent can consent to treatment of child

___ Parents are divorced with joint custody decree providing each parent can consent to treatment for child

___ Parents are divorced with decree granting custody and the right to consent to treatment for child to: ___ mother ___ father

___ ........................................ is (are) child’s legal guardian(s) and each can consent to treatment of child

___ Other (please explain): __________________________________________________________

______________________________________________________________
Patient Name

______________________________________________________________
Parent/Legal Guardian Signature

______________________________________________________________
Relationship to Patient

______________________________________________________________
Date