



Welcome to Still Waters, where you'll find health care professionals dedicated to providing you with the highest level of quality care. We want your experience here to be positive and growth promoting. We know that the decision to enter counseling is often difficult and your counselor will be glad to answer any questions you may have about the counseling process, his or her education and experience, or any concerns you may have.

For change to occur it is necessary to form and experience a trusting, emotionally safe relationship with your counselor, and in the context of that relationship to increase one's awareness of self, challenge one's assumptions, learn new skills, establish appropriate boundaries in relationships with others, and experience and let go of pain from the past. Your counselor's task is to assist in this process. Our aim is to provide consultation, evaluation, and counseling services for clients dealing with issues impacting their well-being.

We have designed this packet to inform you about us and about your rights as a client.

The packet includes:

- Professional Services Agreement
- Notice of Privacy Practices to Protect your Health Information (NPP)
- Acknowledgement of Receipt of NPP and Signature denoting your Consent to Receive Professional Services
- Insurance Verification Form
- Life Functioning Inventory

To help us serve you better, please take your time, read, and complete the information requested in this packet. We ask that you return the following forms to your first appointment with your therapist:

- Acknowledgement of Receipt of NPP and Signature denoting your Consent to Receive Professional Services
- Insurance Verification Form
- Life Functioning Inventory

If you have any questions and would like to receive further information, talk to your counselor during your first appointment.

Thank you,

Robyn J. Kittrell, Ph.D., HSPP
Robin M. Lett, Ph.D., HSPP
Jodi Nixon, Ph.D., HSPP
Carol Dean, Ph.D., HSPP
Paula Emke-Francis, Ph.D., HSPP
Kali Wolken, M.A., LMHC
Brian Hart, M.A., LMHC
George Gaither, Ph.D., HSPP

David Smith, M.A., LMHC
Christina Smith M.A., LMHC
James Linville M.A., LMHC
Beth Trammell, PhD, HSPP
Jackie Camp, Ph.D., HSPP
Joel Chandler, M.A.
Amanda Charboneau, M.A., LMHC
Abby Nethaway, Ph.D., HSPP



Still Waters
PROFESSIONAL COUNSELING, LLC
PROFESSIONAL SERVICES AGREEMENT

Still Waters offers a variety of services including individual, couples and family counseling, testing and assessment services, professional consultation, training and supervision, and medical nutrition counseling and nutrition education. This agreement contains information about Still Waters' professional services and business policies. It is our intention to keep you well informed as to the nature of the services we provide. Then, you can make a good decision about whether Still Waters can meet your needs. Upon reading this document, your signature will be requested, which will represent an agreement between you and your counselor to enter into a professional relationship. You may revoke this agreement in writing at any time.

Thoughts About Counseling

Entering counseling takes courage. People often come to counseling when they are at a crossroads. The path that they have been on has not taken them where they want to go and they come to counseling in search of help and direction. In order for change to take place, the counselor must join with them at the crossroads and together, embark on a voyage of discovery. The success of the journey depends on the relationship that develops between the counselor and client and therefore it is important for the counselor to: create an atmosphere that is collaborative, relaxed, safe and focused; instill hope; create a shared meaning; listen to the client's story; gather information; and work together with the client to establish realistic and attainable goals. Counseling entails making meaningful connections between affective experiences, cognitions, and behavior. The experiences of each person in counseling will be different, because what happens in counseling depends on you and your needs. How you choose to use each session, your particular counselor's approach and experience, and your own knowledge, insight, experience, and motivation will help determine the course and outcome of counseling. Counseling requires an active effort on your part. In order for counseling to be most successful, you will have to work on things talked about both during sessions and during the week.

Professional counseling services can have benefits and risks. Insight and inner awareness often creates a state of disequilibrium and decreased satisfaction in counseling. Since counseling most often involves discussing unpleasant aspects of your life and your family history, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. At times you may feel worse before you begin to feel better. Therefore it is helpful to understand that a sense of disequilibrium can be a desirable step in your healing process. Professional counseling has been shown to have many benefits as it can lead to improved relationships, solutions to specific problems, increased awareness, and a significant reduction in feelings of distress. Although there are no guarantees of what you will experience during the process of counseling, your active participation in the counseling process is necessary for progress to be made. Thus, we encourage you to attend all scheduled sessions.

We at Still Waters are committed to rendering services in a professional manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your counseling goals. However, together we will work to achieve the best possible results.

Your First Appointment

When you come to your first appointment, please bring with you: completed intake paperwork, insurance card(s), and a valid photo ID. If the client is a minor, we will expect the photo ID of a parent/guardian.

The initial appointment is an approximate 50 minute face to face meeting with a counselor. It is an opportunity to share information about your personal history and current situation and receive an evaluation of your needs. By the end of the appointment, your counselor will be able to offer his/her first impressions/recommendations of how best to proceed. If you decided to continue with counseling, your goals for counseling and a tentative plan to achieve these goals will be discussed. During the initial appointment, your counselor will also provide you information about his/her qualifications and practice orientation. You should evaluate this information and decide if you feel comfortable working with your counselor. Professional counseling involves a large commitment of time, money, and energy so it is important to select a counselor with whom you are comfortable. The initial appointment is also a good time to ask questions and address any concerns you may have about counseling. If at the end of the initial meeting some alternative treatment seems indicated, information and/or an appropriate referral will be made.

Appointments

Appointments are set for a specific time and the appointments run for 45 to 50 minutes. *If you find that you must cancel or reschedule an appointment, please notify the office at least 24 hours in advance.* It is difficult to reassign your appointment time to another client on such short notice. Therefore, a \$50.00 fee (which is not covered by insurance) will be charged for appointments cancelled less than 24 hours in advance.

Smoking Policy

We are a healthcare providers' office and are completely smoke-free and tobacco free. This *includes* electronic cigarettes and any other tobacco related paraphernalia.

Contacting Your Counselor

Due to work schedules, your counselor may not immediately be available by phone. However, your counselor will make every effort to return your call on the same day you make it, with the exception of weekends and holidays.

Emergencies

If an emergency arises, please call (765) 281-2952 and leave a message that you are in crisis. Your counselor will return your call as soon as possible. If you are unable to reach your counselor and feel that you can't wait for your counselor to return your call, contact your family physician or go to the nearest emergency room. If your counselor is unavailable for an extended time, you will be provided with the name and number of another Still Waters' counselor to contact, if necessary.

Limits of Confidentiality

The law protects the privacy of all communication between a client and a counselor. In most situations, information about your treatment can only be released if you sign a written authorization form that meets certain legal requirements imposed by HIPAA and/or Indiana law. However, in the following situations, no authorization is required:

- Your counselor may occasionally find it helpful to consult other health and mental health professionals about a client. During consultations, your counselor will make every effort to avoid revealing your identity. Other professionals are legally bound to keep the information confidential. If you have no objections, your counselor will not inform you of a consultation unless it is important to your work together. All consultations will be noted in your Clinical Record (which is called “PHI” in the “Notice of Psychologist’s Policies and Practices to Protect the Privacy of your Health Information.”). Your counselor will also need to communicate information to his/her colleague who is providing emergency coverage if your counselor is unavailable.
- You should be aware that Still Waters Professional Counseling, LLC employs an office manager and administrative assistants. In most cases, protected information will be shared with these individuals for administrative purposes, such as scheduling, billing, and quality assurance. Our staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without our permission.
- If a coroner or medical examiner requests information in the performance of that individual’s duties, then Still Waters may be required to provide it for them.
- If a patient files a complaint or lawsuit against an individual counselor of Still Waters, relevant information regarding that client may be disclosed in order for the agency to defend itself.

There are situations in which we are legally obligated to take actions, which are believed to be necessary in an attempt to protect others from harm and we may have to reveal some information about a client’s treatment. These situations are unusual in this practice; however, it is important that you be aware of them.

- If there is reason to believe that a child is a victim of child abuse or neglect, the law requires that a report be filed with the appropriate government agency, usually the local child protection service. Once such a report is filed, we may be required to provide additional information.
- If there is reason to believe that someone is an endangered adult, the law requires that a report be filed with the appropriate government agency, usually the adult protective services unit. Once such a report is filed, Still Waters may be required to provide additional information.
- If a client communicates an actual threat of physical violence against an identifiable victim or makes statements indicating imminent danger that the patient will use physical violence or other means to cause serious personal injury to others, Still Waters may be required to disclose information in order to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.

- If a client communicates an imminent threat of serious physical harm to him/herself, the center may be required to disclose information in order to take protective actions. These actions may include initiating hospitalization or contacting family members or others who can assist in providing protection.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that is designed to protect the privacy of patient information, provide for the electronic and physical security of health and patient medical information, and simplify billing and other electronic transactions by standardizing codes and procedures. The HIPAA Privacy Rule, which came into effect in April of 2003, creates a minimum federal standard for the use and disclosure of Protected Health Information (PHI) by health care organizations. One of the requirements of the Privacy Rule is that we give to you a Notice of Privacy Practices (NPP) that describes your rights and protections regarding your health care records (PHI). This document is included as part of the Intake Forms Packet that you will need to read prior to your initial appointment. The law requires that your signature be obtained acknowledging that you were provided with this information. Although these documents are long and sometimes complex, it is important that you read them carefully before your first session. We can discuss any questions you have about the procedures at that time.

We at Still Waters are committed to maintaining your confidentiality and the privacy of psychological and medical records and will continue to adhere to psychologist's ethical guidelines, as well as, state and federal law. Furthermore, your counselor will make every effort to discuss confidentiality procedures with you before taking any action and will limit disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you might have now or in the future. The laws governing confidentiality can be quite complex and in situations where specific advice is required, formal legal advice may be needed.

Minors and Parents

Clients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. Because privacy in counseling is often crucial to successful progress, particularly with teenagers, it is Still Water's policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, they will be provided only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. When counseling is complete, a summary of their child's treatment will be provided. Any other communication will require the child's authorization, unless it is the counselor's judgment that the child is in danger or is a danger to someone else, in which case parents will be notified. Before giving parents any information, all matters will be discussed with the child, and if possible, any objections he/she may have will be handled accordingly.

Professional Fees

Payment terms

We require payment at the time of your office visit. Depending on your insurance policy benefits, this payment could be for a co-payment, coinsurance, deductible, or for the entire services rendered at that visit. For your convenience, we accept cash, personal check, Visa, MasterCard and Discover. We strive to

be flexible and understanding of individual circumstances, and we are happy to help with payment arrangements. There is a \$25.00 fee charged for each returned check in addition to the amount of the check. Payment is YOUR responsibility: Our relationship is with you, to provide quality healthcare to you and/or your dependent.

Standard Rates

Intake Assessment (1 st appointment only).....	\$200.00
Psychotherapy and Medical Nutrition Therapy (MNT).....	\$135.00
Family and Couples Counseling.....	\$160.00
Neuropsychological Testing Services	\$160.00 (per hour)
Psychological Testing Services.....	\$150.00 (per hour)
Cancelled/Missed appointments without 24 hr. notice.....	\$50.00
Court Appearances.....	\$200.00 (per hour)
Phone sessions.....	\$65.00 (up to half hour)

Insurance Reimbursement

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Still Waters can provide you with whatever assistance possible in helping you receive benefits to which you are entitled; however, you, not your insurance company, are responsible for full payment of fees. It is very important that you understand what services are covered under your mental health benefits. If you have any questions whether a service will be covered, you should contact your insurance company before the service is provided. This phone number is usually located on your insurance card. We will provide you with whatever information we can and will call the company on your behalf to clear up any confusion.

It is essential that you provide us with complete and accurate information so that we may properly submit billing information to your insurance company (i.e. home address, phone numbers, name and birth date of the subscriber/person who has the insurance policy). We will make every effort to submit claims to your insurance company and promptly provide you with our statements. We will file your claims with your insurance company as a courtesy after services are provided; however, if you notify us not to file it with your Payer we will honor your request. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above [unless prohibited by contract].

Due to the rising cost of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. “Managed Health Care” plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more counseling after a certain number of sessions. While much can be accomplished in short-term counseling, some patients feel that they need more services after insurance benefits end. [Some

managed-care plans will not allow your counselor to provide services to you once your benefits cease. If this is the case, we will do our best to find another provider who will help you continue your counseling.]

Fees involving Legal Services

Any fees relating to foreseen or unforeseen legal action that require your counselor to reproduce records or participate in depositions or court appearances will be the responsibility of the person who is responsible for the uninsured portion of a client's bill. This is without regard to who files the subpoena or initiates the legal action. It is the signor's responsibility to obtain reimbursement from any other party. Fifty percent (50%) of the estimated charges must be paid in advance.

Additional means of Collection

In consideration of the services provided to our clients, the client/responsible party guarantees payment in full of the client's account in accordance with the financial arrangements made at the time of service, or if no arrangements are made, in event of default in payment, reasonable collection agency fees equal to thirty (30%) percent of the delinquent balance and reasonable attorney fees, shall be added to the amount due on the account, plus any applicable court costs.

By providing a cell number, I give prior express consent to receive calls and text messages from the creditor or its third party debt collector at that number, including calls and messages made by using an auto dialer or prerecorded message.

Note to guardians and/or divorced parents of dependents and primary insurance holders: The statement of your dependent will be sent you and you are expected to make prompt payment. Even if you do not believe you are the "responsible party" we expect you to make a payment, and then you can take action on your own to recoup from the party you believe responsible.

Your cooperation with these policies will assure equitable treatment of insurance and non-insurance patients.

Concluding Remarks

Professional counseling is a cooperative endeavor entailing mutual respect, consideration, and responsibility between you and your counselor. The policies outlined above are designed to educate you on our office procedures and to ensure that your counseling is productive. Should you have questions about any policy or procedure, whether mentioned here or not, please feel free to discuss it with your counselor. Also, please feel free to discuss any concerns and questions about your counseling.



NOTICE OF PRIVACY PRACTICES TO PROTECT YOUR HEALTH INFORMATION

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Still Waters may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment, and Health Care Operations”
 - *Treatment* is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
 - *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities within our office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of our office, such as releasing, transferring, or providing access to information about you to other parties.
- “Authorization” is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when we are asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. “Psychotherapy Notes” are notes we have made about our conversation during a private, group, joint, or family counseling session, which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that

authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage. The law provides the insurer the right to contest the claim under the policy.

To Others Involved in Your Healthcare - We may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare.

If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- *As Required By Law* - We may use or disclose your PHI to the extent that is required by law.
- *Child Abuse* – If we believe that a child is a victim of child abuse or neglect, we must report this belief to the appropriate authorities.
- *Adult and Domestic Abuse* – If we believe or have reason to believe that an individual is an endangered adult, we must report this belief to the appropriate authorities.
- *Health Oversight Activities* – If the Indiana Attorney General's Office (who oversees complaints brought against psychologists instead of the Indiana State Psychology Board) is conducting an investigation into our practice, then we are required to disclose PHI upon receipt of a subpoena.
- *Judicial and Administrative Proceedings* – If the patient is involved in a court proceeding and a request is made for information about the professional services we provided you and/or the records thereof, such information is privileged under state law, and we will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety* – If you communicate to us an actual threat of violence to cause serious injury or death against a reasonably identifiable victim or victims or if you evidence conduct or make statements indicating an imminent danger that you will use physical violence or use other means to cause serious personal injury or death to others, we may take the appropriate steps to prevent that harm from occurring. If we have reason to believe that you present an imminent, serious risk of physical harm or death to yourself, we may need to disclose information in order to protect you. In both cases, we will only disclose what we feel is the minimum amount of information necessary.
- *Worker's Compensation* – We may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. You must put this request in writing. However, we are not required to agree with your request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a therapist. On your request, Still Waters will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of your mental health record except in limited circumstances. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment and/or addendum to your mental health record. Your request must be in writing and give a reason for the request. We may deny your request. If we accept your request, we do not delete any information already in your records. If necessary, we will discuss with you the details of the amendment process further.
- *Right to an Accounting* – You have the right to receive an accounting of certain disclosures of PHI. You must put your accounting request in writing. If necessary, we will discuss with you the details of the accounting process further.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of this notice from us when you receive care at Still Waters.

Psychologist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your PHI. We will notify you of the breach as soon as possible but no later than sixty (60) days after the breach has been discovered.
- We will follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes; however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, the new notice will be available upon request, in our office, and on our website.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the HIPAA Privacy Officer, Robyn Palsrok, at Still Waters Professional Counseling at (765) 281-2952.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

This notice was originally effective on April 14, 2003, and was revised on September 23, 2013.



Acknowledgment of Receipt of Privacy Practices to Protect your Health Information

The Still Waters Professional Counseling “Notice of Privacy Practices to Protect your Health Information” provides information about how we may use and disclose protected health information about you. Our Notice of Privacy Practices is subject to change.

I acknowledge that I have received the Notice of Privacy Practices.

Signature of Client or Client’s Representative

Date

Name Printed

Consent to Receive Psychological Services

The Still Waters Professional Counseling “Psychological Services Agreement” provides information about its professional services and business policies.

I acknowledge that I have received the Psychological Services Agreement, am consenting to receive mental health services at Still Waters, and agree to the financial policies as stated. I understand that the services my therapist provides fall within the scope of the provider’s license, certification, and training.

Signature of Client or Client’s Representative

Date

Name Printed

Consent for Insurance Payment

I authorize the use of this signature on all insurance submissions under HIPAA guidelines. I also authorize release of any and all *pertinent* information needed about me, in order to determine benefits payable for related services, to insurance carriers, the healthcare financing administration & their agents. I request the payment of authorized Medicare benefits and/or other insurance benefits be made on my behalf to Still Waters Professional Counseling, LLC for services provided to me. I understand that my therapist reserves the right to charge me for missed visits as outlined in the Professional Services Agreement. I also understand that there will be an additional \$25 fee for any check issued to Still Waters Professional Counseling, LLC returned with non-sufficient funds.

Signature of Client or Client’s Representative

Date

Name Printed



Consent for Treatment for Clients who are Minors

I, _____, being the parent or legal
name of parent/guardian
guardian for my son or daughter _____,
name of son/daughter
born on _____, hereby agree to his/her treatment at Still Waters
date of birth
Professional Counseling, LLC.

I attest that I am the custodial parent of the above named minor, and have legal authority to do all things necessary with regards to seeking therapy/counseling for my child. Any issues concerning divorce, custody, guardianship, probation and/or restraining orders will require all documents to be presented on first visit to verify any legal issues and/or custody of child. Copies of these documents will be kept with minor's records.

I understand that all information regarding diagnosis and/or treatment is confidential and will not be released to any other agency or individual without my knowledge and consent, except when required by law. I understand that Still Waters and my son or daughter's therapist is required to report knowledge of child abuse. I understand that Still Waters and my son or daughter's therapist may break confidentiality if he/she poses a serious threat to harm him/herself or others.

I further understand that my son or daughter's counselor may consult with other health care professionals in order to provide the best treatment possible for him/her.

I have read, understand, and agree to the foregoing.

Signature of Parent or Guardian

Date

Name Printed

Signature of Witness

Date



1904 W. Royale Drive. | Muncie, IN 47304 | 765-284-0043

Minor Intake Form

DEVELOPMENTAL AND PSYCHOLOGICAL HISTORIES/SYMPTOM CHECKLIST

CHILD'S NAME: _____ AGE: _____ DOB _____
SCHOOL: _____ GRADE: _____

Parent/guardian contact information:

Parent/guardian #1 Name: _____

Relationship: _____

Address: _____

Phone number: _____

Email: _____

Parent/guardian #2 Name: _____

Relationship: _____

Address: _____

Phone number: _____

Email: _____

What are the primary concerns you have for your child at this time? When did you start to be concerned about your son or daughter?

Please list the members of your child's current household:

Full Name	Relationship to Child	Age

Other relatives who are important to the child's life but may not be living with the child, i.e., biological father or mother, stepsiblings:

Full Name	Relationship to Child	Age

Has your family/child recently experienced significant stress, change, or trauma (e.g., death of a loved one, a recent move, illness in the family, significant conflict, birth of a sibling, divorce, etc.). Please include details and dates of recent stress.

Has any member of the child's immediate and close extended family (parents, siblings, grandparents, aunts, uncles, cousins) had any of the following? If so, please indicate the relationship to the child.

	Mother's Side	Father's Side
Drug or alcohol abuse		
Depression/mania		
Mental retardation		
Psychosis/schizophrenia		
Sexual/physical abuse		

	Mother's Side	Father's Side
Hyperactivity/inattention		
Anxieties, fears, phobias		
Autism/Asperger's Disorder		
Eating disorder		
Suicide attempts		

Please describe your child's strengths, special talents, skill areas:

Please describe how your child gets along with peers/friends (e.g., shy, trouble making friends, has many friends, picks on other kids).

Please describe how your child gets along with family members (e.g., mother, father, siblings).

Does your family identify with a specific religion?

Yes No If yes, please specify religion: _____

DEVELOPMENTAL/MEDICAL HISTORY

Were there any prenatal complications or complications after birth?

If yes, please describe.

Did your child have any problems from infancy through age 4? (for example, did they have difficulty sleeping, eating, any medical problems, difficulty talking, toilet training, difficulty with separation, behavior problems at home or school, difficulty getting along with siblings or peers).

If yes, please explain.

Does your child have any disabilities? If yes, please describe:

Who is your child's Primary Care Physician? _____

Phone number: _____

Fax number: _____

Please list any medications your child is currently taking:

Name of Medication	Dosage

Please list any medical conditions that your child currently has or has ever had.

Has your child ever been hospitalized? If Yes, list reasons and ages:

Has your child had any serious accidents or traumatic injuries? If Yes, please describe:

ACADEMIC HISTORY

Have you noticed or has your child's teacher ever reported behavioral difficulties in the classroom (e.g., difficulty paying attention, hyperactivity, problems staying seated) or getting along with peers? If Yes, please list grade and describe.

Has your child had any trouble learning or struggled with a particular skill (e.g., writing, reading, math, participating in class) in school? If Yes, please describe.

SYMPTOM CHECKLIST

1. Does your child avoid or have difficulties:

- | | |
|---|--|
| <input type="checkbox"/> getting along with peers | <input type="checkbox"/> making or keeping friends |
| <input type="checkbox"/> interacting with family | <input type="checkbox"/> engaging in social situations |

2. Has your child had any of the following problems with hyperactivity or inattention?

Please check all that apply.

- | | | |
|---|---|--|
| <input type="checkbox"/> problems listening | <input type="checkbox"/> easily distracted | <input type="checkbox"/> difficulty following instructions |
| <input type="checkbox"/> daydream frequently | <input type="checkbox"/> trouble concentrating | <input type="checkbox"/> makes careless mistakes |
| <input type="checkbox"/> difficulty organizing | <input type="checkbox"/> often loses things | <input type="checkbox"/> is fidgety, squirmy, or restless |
| <input type="checkbox"/> has trouble sitting still | <input type="checkbox"/> talks excessively | <input type="checkbox"/> runs or climbs inappropriately |
| <input type="checkbox"/> difficulty playing quietly | <input type="checkbox"/> constantly "on the go" | <input type="checkbox"/> is impulsive |
| <input type="checkbox"/> trouble waiting for turn | <input type="checkbox"/> often interrupts | <input type="checkbox"/> blurts out answers |

3. Has your child had any of the following problems with separation from home/parents/caregivers? Please check all that apply.

- fears being separated from caregiver
- fears caregiver being harmed
- fears going to school
- has excessive fear being alone
- is reluctant to go to sleep at night
- is reluctant to stay with a babysitter
- has nightmares about being separated
- is reluctant to sleep away from home
- has physical complaints when away from home (e.g., stomachaches, headaches)

4. Has your child had any of the following behavior problems in the last 12 months? Check all that apply.

- threatened/intimidated others
- initiated physical fights
- used a weapon
- cruelty to animals or people
- truant from school
- set fires
- destroyed property
- burglarized property
- stolen
- excessive lying or manipulation
- run away from home
- trouble with legal system
- engaged in aggressive sexual behavior

5. Has your child had any problems with disobedience in the past 6 months? Please check all that apply?

- repeatedly lost temper
- often argued with adults
- been deliberately annoying
- blames others
- acted angry/resentful
- is easily annoyed
- acted spiteful/vindictive
- defied adult requests or rules

6. Has your child had any problems with anxiety over the past 6 months? Please check all that apply.

- restless, keyed up
- easily fatigued
- difficulty concentrating
- difficulty sleeping
- ruminates
- worry about performance
- worry about the future
- muscle tension
- easily pressured
- irritability
- perfectionism
- requires excessive reassurance
- bothered by recurrent and persistent disturbing thoughts
- overly concerned with washing, cleaning, counting, checking, repeating actions and ordering

7. Has your child had concerns surrounding body image or weight over the past year?

Check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> excessive fear of weight gain | <input type="checkbox"/> excessive fear of weight loss |
| <input type="checkbox"/> refused to maintain normal weight for age/height | <input type="checkbox"/> excessive dieting |
| <input type="checkbox"/> evaluates self according to body weight | <input type="checkbox"/> uses laxatives, diuretics, speed |
| <input type="checkbox"/> self-induced vomiting after meals | <input type="checkbox"/> binge eating |
| <input type="checkbox"/> severely restricts calories | <input type="checkbox"/> exercises excessively |

8. Has your son or daughter used any substances? Check all that apply.

- | | | |
|--|--|--|
| <input type="checkbox"/> alcohol | <input type="checkbox"/> amphetamines, speed, diet pills | <input type="checkbox"/> marijuana |
| <input type="checkbox"/> cocaine/crack | <input type="checkbox"/> sedatives, hypnotics, anxiolytics | <input type="checkbox"/> hallucinogens (LSD) |
| <input type="checkbox"/> inhalants | <input type="checkbox"/> opioids (heroin, morphine) | <input type="checkbox"/> PCP |

9. Has your son or daughter struggled with any of the following problems with their mood?

Check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> irritable, depressed, sad mood | <input type="checkbox"/> loss of interest in pleasurable activities |
| <input type="checkbox"/> changes in appetite | <input type="checkbox"/> changes in weight |
| <input type="checkbox"/> problems with sleep | <input type="checkbox"/> restlessness and/or lethargy |
| <input type="checkbox"/> fatigue, decreased energy | <input type="checkbox"/> feelings of worthlessness/excessive guilt |
| <input type="checkbox"/> difficulty concentrating | <input type="checkbox"/> preoccupation with thoughts of death/suicide |
| <input type="checkbox"/> periods of enormous energy with little need for sleep | |

10. Does your child frequently suffer from the following physical complaints? Check all that apply.

- | | | |
|---|--|--|
| <input type="checkbox"/> headaches | <input type="checkbox"/> backaches | <input type="checkbox"/> muscle aches, soreness, tension |
| <input type="checkbox"/> stomach problems | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> dizziness or lightheadedness |

11. Has your child ever complained of the following:

- hearing voices talking to him/her
- experienced visual hallucinations (e.g., seeing something that isn't there)
- had bizarre or very unusual thoughts/beliefs

12. To your knowledge, has your child been sexually victimized (fondled, sexually abused, raped)?

Yes No

13. Has your child ever been physically or emotionally abused?

Yes No

14. Have CPS charges or complaints been filed regarding your son or daughter?

Yes No

15. Are there currently any legal problems or custody disputes that involve your son or daughter?

Yes No

16. Who is the child's legal guardian (has the legal authority to provide consent for child to receive treatment)?

This document has been reviewed by:

Provider name(print): _____

Provider Signature: _____ Date _____