NEW PATIENT REGISTRATION

ADOLESCENT AGES 13-17

Name:_____
First Middle Initial Last

Address:_____
City State Zip

Date of Birth:_____ **Gender**: ☐ Male ☐ Female **SSN**:_____ **Marital Status:** ☐S ☐M ☐D

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Employer: _____ **Employer Work Number:** _____

Emergency Contact: _____
Name Number Relation

Primary Care Physician: _____
Name Number

FINANCIALLY RESPONSIBLE PARTY (GURANTOR) INFORMATION (IF SAME AS ABOVE, PUT "SELF")

Guarantor Name: _____ **DOB:** _____ **SSN:** _____

Mailing Address:_____
City State Zip

Relationship to patient: ☐**Spouse/Significant Other** ☐**Mother** ☐**Father** ☐**Sibling** ☐ **Court ordered** ☐**Other** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Guarantor Employer and Phone Number: _____

As required by law, all minors under the age of 18 must be accompanied by a parent/legal guardian to see the therapist.

PLEASE TURN THIS FORM OVER AND FINISH FILLING OUT THE INFORMATION ON THE OTHER SIDE

PRIMARY INSURANCE INFORMATION

Name of Major Medical Insurance Company | Name of Insured (If Other Than Patient)

Member/Policy I.D. Number | Group Number

Address of Insured | Insured Employer

Insured Social Security Number | Insured Date of Birth

Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other

SECONDARY INSURANCE INFORMATION

Name of Major Medical Insurance Company | Name of Insured (If Other Than Patient)

Member/Policy I.D. Number | Group Number

Address of Insured | Insured's Employer

Insured Social Security Number | Insured Date of Birth

Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other

Assignment of Benefits: I hereby authorize and request my insurance to pay directly to Oasis Behavioral Health Services the amount due for services rendered to me or my dependent.

Release of Information: I authorize the release of any medical information necessary to process this claim. This may include, but not be limited to, an outpatient treatment summary describing prognosis, frequency of treatment, and/or medications prescribed. This is a continuing consent for release of psychotherapy and/or substance abuse records for the duration of my treatment or until rescinded in writing.

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 Oasis Behavioral Health Services. I understand Oasis Behavioral Health Services may take legal action to obtain payment if my account is in arrears and I have not made prior arrangements for payment. I will be responsible for any fees involved in the collection of this debt if sent to an outside collection agency or attorney. These fees will be added to my total amount due.

Signature (Patient signature, if patient is guarantor.) Date

Parent/Guardian Signature Witness Signature Date

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

_____ _____

Patient Name Date

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER *(check all that apply)*:

Home Telephone Number: _____

- ❑ O.K. to leave message with detailed information
- ❑ Leave message with call-back number only

Written Communication

- ❑ O.K. to mail to my home address
- ❑ O.K. to mail to my work/office address
- ❑ O.K. to fax to this number: _____

Work Telephone Number: _____

- ❑ O.K. to leave message with detailed information
- ❑ Leave message with call-back number only

Other: _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

RECORD OF DISCLOSURES OF PROTECTED HEALTH INFORMATION (FOR OFFICE USE ONLY)

DATE	DISCLOSED TO WHOM ADDRESS OR FAX #	(1)	DESCRIPTION OF DISCLOSURE/ PURPOSE OF DISCLOSURE	BY WHOM DISCLOSED	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T = Treatment Records, P = Payment Information; O = Healthcare Operation
(3) Enter how disclosure was made: F = Fax, P = Phone, E = Email, M = Mall, O = Other

Notice of Privacy Practices

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public, we will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement, if you are an inmate or under the custody of a law enforcement official.
8. For Workers' Compensation and similar programs.

Your rights regarding your health information

1. Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information of only certain individuals involved in your care of the payment of your care, such as family members and friends. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to your physician practice.
4. To request an amendment, your request must be made in writing and submitted to your physician. You must provide us with a reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of the notice at any time.
6. Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Shawn R. Cade; PO Box 219; Barboursville, WV 25504. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures: We will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

_____	_____
Patient Signature	Parent/Guardian Signature
_____	_____
Witness Signature	Date

POLICIES

Thank you for choosing Oasis Behavioral Health Services. To ensure the privacy, respect, and courtesy to our patients, we enforce the following policies. Please do not hesitate to ask us if you have any questions.

Patient Name **(Print)**:_____ Birth Date:_____ Date:_____

Please initial each box to indicate that you have read and agree with these policies, and provide your full signature in the area indicated below by the (X). Thank you.

	See your doctor: If you have not had a physical examination in the past six months, please get a physical exam from your personal physician as soon as possible. Please ask your doctor to send us a copy of your physical exam results.
	Confidentiality: With a few exceptions, our conversations are confidential. State law, HIPAA regulations, and our codes of ethics specifically guarantee privacy. There are some situations, however, in which confidentiality cannot be guaranteed. They fall within the following categories: a. We must notify appropriate persons if we believe that a patient is an imminent danger to themself or others. b. We must report chid abuse or the abuse, neglect, or exploitation of the elderly. c. We will have to respond to a subpoena accompanied by a court order. d. If you are a participant in an insurance or managed care program, your contract may permit administrative access to your therapy record and require that we consult with your physician.
	Payments: Payment of co-pays, deductibles, or any balances not covered by insurance is **due at the time of service**. Returned checks are subject to a $25 fee. Postponement of services may occur under these conditions: No payment on account in the past 45 days, and/or your account is $150 or more in arrears. There will be a $3.00/month statement fee added to all unpaid balances.
	Appointment Cancellations: If you are unable to make your appointment for any reason, please cancel and reschedule as soon as possible. This allows us time to give your slot to someone on our waiting list. Failure to give 24 hours notice will result in a $50.00 missed or late-cancel charge to your account. This charge is not billable to your insurance company, and will be payable at your next scheduled visit. Missed-visits or cancellations for three consecutive appointments may warrant discharge from this episode of care.
	Incidental Fees: I acknowledge there may be charges my insurance might not cover that are necessary to facilitate care. These charges may include urine drug screens, testing, and/or educational materials. Oasis Behavioral Health Services will make every effort to inform you prior to providing the service, but we may not always know in advance. Your session fee may vary according to the service provided. I agree to be responsible for paying these charges.
	Charges for Telephone Consultations: Telephone consultations are *not* covered under insurance benefits. Any phone consultations are pro-rated by time and will be your responsibility to pay at the time of service or at your next scheduled appointment. You will also be responsible for charges related to case management consultations that your clinician determines is necessary to manage your care.
	Form Fees: There may be a charge for completion of reports or forms including, but not limited to: FMLA forms, disability forms, Workers' Compensation, record copying for legal purposes, etc. Fees will need to be paid in full before reports, copies, or forms are released. Check with your therapist for fee information.
	Emergencies: If you feel you need help and cannot reach your therapist, please contact your closest hospital E.R. or your local community mental health center. If your emergency is medication-related, then please contact the prescribing physician.
	Privacy Policy: I acknowledge being offered OBHS's "Notice of Privacy Policies and Client's Rights" form.
	Informed Consent: Before obtaining any medical or counseling care, it is important to gain sufficient knowledge regarding the types of treatment available, any risks, and potential benefits. This is done to ensure you can make well-reasoned decisions about your treatment. Your clinician will discuss with you the methods of therapy and any risks that may arise, and will be available to assist you in making any changes, and to help you understand their impact on you and others. We will always keep you informed of any changes in therapy we propose and any risks we foresee**.**
	Termination of Services: If you choose to stop treatment, we would appreciate a one week notice so that we might meet to discuss the cessation of services and your future plans. If you prefer, we can assist you in locating another provider. We also have the right to terminate services, and will provide you notice appropriate to termination conditions. Three consecutive failed-visits may result in temporary or permanent cessation of services.
	Electronic Communication and Social Networking: If you choose to communicate with anyone in this office by electronic means; i.e., cell phone, email, Facebook, Twitter, texting, etc., please be aware that confidentiality can ***not*** be guaranteed. Therefore, you are urged ***not*** to disclose any information via digital format that you would also not want made public. ***A special note about Facebook and Twitter:*** Individual clinicians in this office will ***not*** "friend" you on Facebook or "follow" you on Twitter, which could be interpreted as therapeutic boundary crossing. If you choose to "friend" us, please do so through our agency site at: http://www.Facebook.com/oasisbehavioralhealth.

X _____ _____/_____

Patient Signature | Parent/Guardian Signature | Date

_____

Witness Signature

OASIS BEHAVIORAL HEALTH SERVICES, L.L.C.

CONSENT TO TREAT A MINOR

I, _____, custodial parent/legal guardian of
(Parent/Guardian Name)

_____, age _____authorize:
(Name of Child)

OASIS BEHAVIORAL HEALTH SERVICES, LLC to assess and treat my child in an outpatient, psychological, counseling and psychiatric setting.

I agree to take part in the counseling process as needed, and understand the format of counseling may include any combination of the following: individual sessions with minor child, family sessions, and sessions with the parent(s). The treatment may also include recommendations for medications. If this occurs, you will be fully advised, so that you can make an informed decision about this mode of treatment.

Parent/Guardian Signature _____ Date _____

Relationship to Minor _____ Signature of Minor _____

Signature of Counselor _____Date _____

CHILD CUSTODY PAYMENT AGREEMENT

In the case of a divorce where there is a minor child receiving service from OASIS BEHAVIORAL HEALTH SERVICES, we must have one parent act as the legal guarantor for payment of services.

Any signature and contact information below acknowledges that I am responsible for the full payment of all fees for services provided by Oasis Behavioral Health Services (less any amount paid by a third party payer).

_____ _____
Print Name Address

_____ _____
Phone # City, State, Zip

_____ _____ _____
Social Security # Date of Birth E-mail

_____ _____
Emergency Contact Emergency Contact Phone Number

Signature:_____ Date: _____

************Please provide a copy of your Driver's License to the receptionist**************

OASIS Behavioral Health Services, L.L.C.
689 Central Avenue
P.O. Box 219
Barboursville, West Virginia 25504-0219
Office - 304-733-3331 Fax - 304-733-3334
E-Mail - wbwobhs1@aol.com
Website: www.PsychOasis.com

PSYCHOSOCIAL HISTORY
Adolescent (13 - 17 Years Old)

(Part 1)
(Adolescent)

Please complete the form as fully as possible. The purpose is to obtain a complete and accurate profile of you to assist us in helping you as quickly as possible. Please complete all questions to the best of your ability, and as honestly as you can. If there is any question which does not pertain to you, just write N/A (not applicable) in the space provided. Please note there are questions on the front and back of each page.

If you are uncomfortable with answering any part(s) of this questionnaire, simply leave it blank and speak to your therapist about it.

Your therapist will review this with you to assure accuracy and to elaborate where indicated.

This information is CONFIDENTIAL. It will not be shared with anyone outside this office without your written permission or a court order except in the following circumstances:

- A court order
- If you are in danger of hurting yourself or others, (this may include alcohol and/or drug use)
- If you are being abused

Again, please complete each question, front and back pages. Thank you.

For office use only:

Reviewed with client: (Date)_____

Clinician's Initials: _____

1. **Identification Data:** (To be completed by the adolescent)

   Name:_____

   Address:_____

   Home Phone:_____ Parent's Work Phone (if applicable):_____

2. **Problem Description:** Describe in your own words why you came here:_____

   _____

   _____

   What caused you to seek help at this time?_____

   _____

3. **Patient/Client Severity Rating:** (Please check one.)
   How severe is your problem(s?

   Scale = ___ 1 = mild
   ___ 2 = moderate
   ___ 3 = marked
   ___ 4 = severe
   ___ 5 = extreme

4. **Symptom Checklist:** (Check any symptoms you have recently experienced.)

___depressed mood
___nervousness
___loss of energy
___lack of motivation
___sudden weight change
___headaches
___excessive exercising
___upset stomach
___chest pain/tightness
___confusion
___memory problems
___indecisiveness
___fear of people, places, things
___numbness
___temper outbursts
___racing thoughts
___hearing voices (others don't)
___panicky
___taking sedatives
___using pain killers
___alcohol problems
___binging/purging of food
___bowel disturbance
___disturbed sleep
___nausea
___vomiting
___crying spells
___faintness or dizziness
___appetite change
___withdrawal from family/friends
___strange thoughts
___use of diet pills
___difficulty concentrating
___excessive fears
___rapid heart beat
___shortness of breath
___lump in throat
___shyness
___excessive worry
___seeing things (others don't)
___inattentiveness
___excessive sweating
___**suicidal ideas**/thoughts of hurting self
___**homicidal ideas**/thoughts of hurting others
___allergies
___nightmares
___loss of control over behavior
___sexual activity

FOR FEMALES ONLY: (Check all that apply.)

___irregular or frequent periods
___very heavy periods
___spotting between periods
___abortion
___painful periods
___vaginal discharge or itching
___child birth
___pregnancy

Date of last cancer smear (PAP):_____
Did your mother take any drugs, alcohol or hormones while she was pregnant with you?
___Yes ___No ___Don't know

5. <u>Problem Checklist:</u> I am seeking help for (Check all that apply.)

___emotional/psychological problems
___couples problems
___job problems
___sexual problems
___financial problems
___death of a loved one (grief)
___chemical use in another person
___poor grades
___family problems
___school problems
___alcohol and/or drug problems
___legal problems
___health problems
___behavioral problem in another person
___self hate
___other (please describe)_____

6. <u>Substance Use:</u>

A. <u>Alcohol and/or Drug Use:</u>

Do you drink alcohol? ___Yes ___No
Do you use (non-prescribed) drugs? ___Yes ___No
Do you ever use drugs and alcohol together? ___Yes ___No
Do you abuse prescribed drugs? ___Yes ___No

If you answered "yes" to any of the above, what is your favorite (usual) alcoholic beverage and/or drug of choice?_____

How often do you drink/use? (check one)

___ **less** than two times per week
___ **more** than two times per week

How many drinks/drugs per occasion? (check one)

___ **less** than four drinks per occasion
___ **more** than four drinks per occasion

When was the last time you consumed: Alcohol_____(date)

When was the last time you consumed: Drugs_____(date)

(C) Have you ever felt you should <u>cut down</u> on your drinking/using? ___Yes ___No
(A) Have you ever felt <u>annoyed</u> when people talk about your drinking/using? ___Yes ___No
(G) Do you ever feel <u>guilty</u> about your drinking/using? ___Yes ___No
(E) Do you ever drink/use early in the day, as an "<u>eye opener</u>"? (To steady your nerves or make you feel normal.) ___Yes ___No

(Associated problems due to drinking/using drugs (Check all that apply.):

Problems at home	___Yes	___No
Problems at school	___Yes	___No
Problems with the law	___Yes	___No
Getting along with others	___Yes	___No
Avoid old friends while using	___Yes	___No
Have a problem with alcohol/drugs	___Yes	___No
A relative with alcohol/drug problems	___Yes	___No

Do you now, or have you ever used any of the following substances:

___marijuana
___diet pills
___tranquilizers
___laxatives
___diuretics (water pills)
___cocaine or crack
___heroin
___opium
___inhalants (gasoline, freon, glue, etc.)
___pain killers
___sleeping medications
___barbiturate (downers)
___amphetamines (speed)
___ecstacy
___anabolic steroids
___methamphetamine (ice)
___hashish
___designer drugs (look-alikes)

B. Compulsive Behavioral Problems: (Check any you, or someone else, think(s) may be a problem:)

___gambling
___sexual acting out
___eating disorder (binge/purge or restrict)
___dependent relationship
___obsessive/compulsive behaviors
___sexual offender
___physically abusive
___child of alcoholic
___religious abuse/addiction
___victim of physical abuse
___overspending
___overeating
___explosive temper
___tobacco use
___caffeine use
___dysfunctional family
___victim of sexual abuse
___unsatisfactory relationships
___self-mutilating behavior
___victim of emotional abuse

7. **<u>Physical Symptom Checklist:</u>** Place a check (✓) in front of any of the following that are or have been a problem for you. **Double**-check (✓✓) the problems that are current.

A. ___rashes, color change
___itching
___warts
___eczema, lumps, hives
___excessive sweating
___bleeding or bruising from minor injury
___anemia
___lymph node or gland swelling

B. ___ear trouble, infection
___hearing loss, ringing in your ears
___eye problems
___nosebleeds

F. ___enlarged or painful breasts
___breast lumps
___discharge from nipples
___very dry skin

G. ___shortness of breath
___cough, chest colds
___bringing up sputum or blood
___wheezing, asthma
___chest pain, pleurisy
___TB or exposure to TB
___fever, sweats, chills
___pneumonia

___stuffy nose, sinus trouble, hay fever
___hoarseness
___dental or gum problems

C. ___chest pain, tightness, pressure
___fast or irregular heartbeat
___trouble breathing when lying down
___shortness of breath
___swelling of feet or ankles
___heart trouble
___murmurs or rheumatic fever
___high blood pressure
___poor circulation, varicose veins
___blood clots

D. ___pain or burning on urination
___trouble starting or stopping urine
___blood or pus in urine
___frequent urinating
___waking to urinate
(number of times per night_____)
___soreness or discharge
___sexually transmitted diseases (STD)

E. ___trouble swallowing
___hernia
___poor appetite
___gas, cramps, pains
___heartburn, indigestion
___nausea, vomiting
___constipation, diarrhea
___yellow jaundice, hepatitis
___hemorrhoids
___gall bladder problems

H. ___pain in joints, arthritis
___swollen joints
___back pain, neck pain

I. ___head injury, concussion
___sexual problems
___headaches
___dizziness, fainting
___convulsions, seizures, fits
___shaking, tremor
___weakness, paralysis
___numbness, tingling
___difficulty walking, coordination
___depression, anxiety
___poor sleeping
___nervousness, tension
___trouble thinking, remembering
___crying, upset, worrying

J. ___cancer
___diabetes
___goiter, thyroid problem

***Note to Health Care Provider:**
See *Medical History: Section 7* (Part 2) of Adolescent Psychosocial History - Parent/Guardian form.

8. Sexual History

Are you sexually active? ___Yes ___No
If so, do you use birth control and/or protection? ___Yes ___No
Have you ever had a sexually transmitted disease? ___Yes ___No

9. Education

Current school:_____ Grade level:_____

Current teacher:_____ Current school counselor:_____

Are you concerned/worried about your grades? ___Yes ___No
Do you have difficulties with teachers or peers? ___Yes ___No
Have you been suspended or expelled from school? ___Yes ___No

If yes, why?_____

10. **Legal:** Have you ever been:

Arrested ___Yes ___No
Convicted ___Yes ___No
Incarcerated ___Yes ___No
On probation ___Yes ___No If yes, give Probation Officer's name:_____

If yes, when:_____

Where:_____

What for:_____

11. **Family History:** Please list the members of your family (use back of page if necessary.)

Name	Relationship To You	Their Age

How are you disciplined at home? (Check all that apply.)

___spanking
___grounded
___removal of privileges
___yelled at
___withhold allowance
___extra work/chores
___time out
___nothing

Other:_____

12. **Goals:** What are your goals for treatment? What would you like to be different about your life as a result of coming here?

A._____

B._____

C._____

Thank you for taking the time to complete this form.

_____ _____
(Your Signature) (Date)

OASIS Behavioral Health Services, L.L.C.
689 Central Avenue
P.O. Box 219
Barboursville, West Virginia 25504-0219
Office - 304-733-3331 Fax - 304-733-3334
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PSYCHOSOCIAL HISTORY
Adolescent (13 - 17 Years Old)

(Part 2)
(Parent/Guardian)

Please complete the form as fully as possible. The purpose is to obtain a complete and accurate profile of you to assist us in helping you as quickly as possible. Please complete all questions to the best of your ability, and as honestly as you can. If there is an question which does not pertain to your teen, just write N/A (not applicable) in the space provided. Please note there are questions on the front and back of each page.

If you are uncomfortable with answering any part(s) of this questionnaire, simply leave it blank and speak to your therapist about it.

Your child's therapist will review this with you to assure accuracy and to elaborate where indicated.

This information is CONFIDENTIAL. It will not be shared with anyone outside this office without your written permission or a court order.

Again, please complete each question, front and back pages. Thank you.

For office use only:

Reviewed with client: (Date)_____

1. **General Information:**

Adolescent's name:_____ Date of birth:_____

Legal guardian:_____

Legal guardian's address:_____

Adolescent lives with:_____

Phone number (home):_____ (School):_____

Father's name (if applicable):_____

Father's occupation:_____ Social Security #:_____

Father's education:_____ Father's age:_____

Mother's name:_____

Mother's occupation:_____ Social Security #:_____

Mother's education:_____ Mother's Age:_____

Marital status of parents: ___Married ___Single ___Divorced ___Widowed ___Cohabitating

If parents are separated/divorced, how old was the adolescent when this occurred?_____

Method of payment for services:_____

2. **If Applicable:**

Stepfather's name:_____ Occupation:_____

Stepmother's name:_____ Occupation:_____

3. **Referral Source:**_____

4. **Presenting Problem:** Please list your current concerns about your adolescent:

A. _____

B. _____

C. _____

When did problems begin?_____

Previous treatment:

Therapist:_____

Address & phone#:_____

Psychiatrist:_____

Address & phone#:_____

Medications prescribed (if applicable):_____

5. School Information:

Current school:_____ Grade Level:_____

Name of school counselor:_____

Has his/her grades gone down in recent months? ___Yes ___No
Does he/she have any behavior problems at school? ___Yes ___No
Has he/she been suspended or expelled from school? ___Yes ___No
Any history of Attention Deficit Disorder or other learning disability? ___Yes ___No

6. Developmental History: During pregnancy, did mother experience any of the following:

___excessive vomiting
___excessive spotting or blood loss
___infection(s)
___illnesses or operations
___X-rays during pregnancy
___medications taken during pregnancy
___hospitalization for complications
___threatened miscarriage
___toxemia (fluid retention)
___smoking during pregnancy
___full term pregnancy
___use alcohol, drugs, or cigarettes during pregnancy
If yes, please list_____
___required incubator

Check if your child has experienced problems with any of the following developmental milestones:

___developed appetite
___appropriate sleep pattern
___smiling
___crawling
___walking
___speaking
___motor coordination
___bed wetting
___potty training
___riding tricycle
___riding bicycle
___dressing self
___reciting alphabet
___beginning to read

Was there any pregnancy or delivery complications? If so, please describe:_____

_____

Was jaundice, infection, Rh factor, or cyanosis (turning blue) present? (If so, circle applicable condition.)

_____

Were there any birth defects? If so, please describe:_____

_____

Describe his/her personality during infancy:_____

_____

7. **Medical History:**

Pediatrician name:_____

Address/phone #:_____

Current medical problems:_____

Hospitalizations:_____

List any medications your adolescent is currently taking, including dosage:

Medication	Dosage	Frequency	Prescribed By
(Example) Phenobarbital	15 mg.	Two times a day	Dr. Ross

List any psychiatric problems in the immediate or extended family (substance abuse, anxiety, depression, mood surges, suicide, etc.):_____

_____

Do you suspect your adolescent may have an eating disorder? ___Yes ___No

Do you suspect any abuse of alcohol or drugs by your adolescent? ___Yes ___No If so, what?_____

Do you feel that your adolescent is being sexually active? ___Yes ___No ___Not sure

8. **Social and Psychological History:** List any stressors your adolescent has experienced in the past three years (i.e.: deaths of significant others, divorce of parents, etc.)_____

_____

Has your child experienced any of these types of abuse:

Physical: ___Yes ___No If yes, please explain:_____

_____

Sexual: ___Yes ___No If yes, please explain:_____

_____

Verbal: ___Yes ___No If yes, please explain:_____

_____

Emotional: ___Yes ___No If yes, please explain:_____

_____

Does your adolescent engage in any dangerous behaviors such as: self-mutilation, aggressive behavior, or threaten to harm him/herself or others? If so, please explain:_____

_____

_____

Does your adolescent demonstrate any of the following symptoms? (Check all that apply)

___increase or decrease of sleep
(if yes, underline which one)
___increase or decrease of appetite
(if yes, underline which one)
___increased irritability
___increased apathy
___loss of motivation
___alcohol or drug abuse
___isolating from peers/family members
___crying spells
___**suicidal** ideas, threats or attempts
___feelings of hopelessness
___increased anxiety
___sexually active
___loss of interest in usual activities
___decreased concentration
___drop in grades
___neglecting personal hygiene
___increased somatic complaints
(headaches, backaches, etc.)
___heart palpitations
___racing thoughts
___panicky feelings
___hyperventilation
___nervousness
___muscle tension
___irritability
___excessive worry
___violence
___other:_____

9. **Outcome Questions:** Treatment Goals

What would you like to be different as a result of your adolescent's treatment?_____

_____

_____

_____

_____

How do you think we can be helpful to you and your child? Please be as specific as possible:_____

_____

_____

_____

_____

May we contact your child's primary care physician? Yes___ No___

Primary Care Physician's (PCP) Name:_____

PCP Address:_____

_____

PCP Phone #:_____

_____ _____

Your Signature Today's Date

_____

Your Relationship to Adolescent

Thank you for taking the time to complete this form.

Has your child experienced any of these types of abuse:

Physical: ___Yes ___No If yes, please explain:_____

_____

Sexual: ___Yes ___No If yes, please explain:_____

_____

Verbal: ___Yes ___No If yes, please explain:_____

_____

Emotional: ___Yes ___No If yes, please explain:_____

_____

Does your adolescent engage in dangerous behaviors such as: self-mutilation, aggressive behavior, or threatening to harm him/herself or others? If so, please explain:_____

_____

_____

Does your adolescent demonstrate any of the following symptoms? (Check all that apply.)

___ increase or decrease of sleep
(If yes, underline which one)
___ increase or decrease of appetite
(If yes, underline which one)
___ increased irritability
___ increased apathy
___ loss of motivation
___ alcohol or drug abuse
___ isolating from peers/family members
___ crying spells
___ **suicidal** ideas, threats or attempts
___ feelings of hopelessness
___ increased anxiety
___ sexually active
___ loss of interest in usual activities
___ decreased concentration
___ drop in grades
___ neglecting personal hygiene
___ increased somatic complaints
(headaches, backaches, etc.)
___ heart palpitations
___ racing thoughts
___ panicky feelings
___ hyperventilation
___ nervousness
___ muscle tension
___ irritability
___ excessive worry
___ violence
___ other:_____

9. **<u>Outcome Questions:</u>** Treatment Goals:

What would you like to be different as a result of your adolescent's treatment? _____

_____

_____

_____

How do you think we can be helpful to you and your child? Please be as specific as possible: _____

_____

_____

_____

May we contact your child's primary care physician? Yes____ No____

Primary Care Physician's (PCP) Name: _____

PCP Address: _____

_____

PCP Phone #: _____

_____ _____
(Your Signature) (Today's Date)

_____
(Your Relationship to Adolescent)

<u>Thank you for taking the time to complete this form.</u>