CHILD AND ADOLESCENT INFORMATION FORM - *CONFIDENTIAL*

- for children 16 and under this form must be completed by a parent -

NAME OF CHILD: ______________________ AGE: ________ DATE: ____________

DATE OF BIRTH: ____________ GENDER: M F SCHOOL: ____________ GRADE: __________

NAME OF PERSON COMPLETING FORM: ______________________________

RELATIONSHIP TO CHILD: ______________________________

HOME PHONE: ( ) ____________ May we call you there? Yes ☐ No ☐ Leave a message? Yes ☐ No ☐

WORK PHONE: ( ) ____________ May we call you there? Yes ☐ No ☐ Leave a message? Yes ☐ No ☐

ADDRESS ______________________________ CITY ______________ ZIP __________

PERSON RESPONSIBLE FOR PAYMENT ______________________ Relationship to client ______________

ADDRESS (if different from client) ______________________________

Responsible party's employer ______________________ Responsible party's driver's license: State _____ Lic. No. ____________

1. Primary Insurance Carrier ______________________ Address ______________________________

Insured's Name ______________ Social Security # ____________ Group Name ____________ Group # ____________

2. Secondary Insurance Carrier ______________________ Address ______________________________

Insured's Name ______________ Social Security # ____________ Group Name ____________ Group # ____________

ASSIGNMENT OF INSURANCE BENEFITS:

I, the undersigned, assign all medical benefits, including major medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize my provider to release any information necessary to secure the payment of benefits. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

SIGNATURE ______________________________ DATE ______________

In case of an emergency whom should we contact for you? Person : ______________________________

Phone number: ( ) ______________________ Person's relationship to you: ______________________

WHO REFERRED YOU TO US? ______________________________

Has your child ever been seen by other mental health professionals? No Yes If so, who? ______________________

Please answer the following questions as carefully and completely as possible. The questionnaire is lengthy, but we normally ask all these questions during counseling. Completing this form will allow more time for counseling. **This information will be kept strictly confidential.** (See page 4 for more information about confidentiality.) **No information will be released without your written permission.**

Briefly describe the situation for which you are seeking counseling: ______________________________

____

____

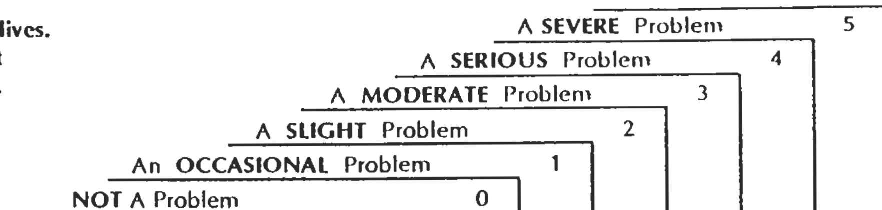
Why now? ______________________________

What are your goals for your child's therapy? ______________________________

____

____

Below are some ways that problems impact children's lives. Please read each item and then circle the response that best describes your child. Use the rating scale at right.



Item	0	1	2	3	4	5
SCHOOLING						
Absenteeism / lateness	0	1	2	3	4	5
Relating to teachers	0	1	2	3	4	5
Relating to other students	0	1	2	3	4	5
Grades dropping	0	1	2	3	4	5
Other school problems ______________________	0	1	2	3	4	5
BEHAVIOR						
Hurting him or herself (How? ______________________)	0	1	2	3	4	5
Compulsively repeating certain behaviors (What? ______________________)	0	1	2	3	4	5
Being teased by family or peers / teasing others ←(circle all that apply)	0	1	2	3	4	5
Trouble making friends / keeping friends ←(circle all that apply)	0	1	2	3	4	5
Tries to get along with everyone	0	1	2	3	4	5
Wetting the bed	0	1	2	3	4	5
Destroying things / setting fires ←(circle all that apply)	0	1	2	3	4	5
Arguing excessively	0	1	2	3	4	5
Aggressive behavior	0	1	2	3	4	5
Lying excessively	0	1	2	3	4	5
Stealing	0	1	2	3	4	5
Using alcohol or drugs	0	1	2	3	4	5
Withdrawing from others	0	1	2	3	4	5
Restlessness	0	1	2	3	4	5
Sneaking out or running away	0	1	2	3	4	5
Hurting animals or being cruel to animals	0	1	2	3	4	5
FEELINGS AND MOODS						
Depressed mood / sadness / crying	0	1	2	3	4	5
Sudden mood changes	0	1	2	3	4	5
Anxiety / fears / nervousness ←(circle all that apply)	0	1	2	3	4	5
Feeling angry or irritable	0	1	2	3	4	5
Doesn't like to be alone	0	1	2	3	4	5
Not liking him or herself	0	1	2	3	4	5
THINKING AND IDEAS						
Forgetfulness	0	1	2	3	4	5
Repeating certain thoughts over and over and being unable to stop	0	1	2	3	4	5
Complaining about health and physical problems	0	1	2	3	4	5
Threatening to hurt others	0	1	2	3	4	5
Seeing or hearing things others do not see or hear / visions	0	1	2	3	4	5
Suicidal statements or threats	0	1	2	3	4	5
HOW MUCH OF A PROBLEM IS YOUR CHILD HAVING WITH:						
Headaches	0	1	2	3	4	5
Sleeping too much	0	1	2	3	4	5
Insomnia (Can't sleep much even though he or she tries)	0	1	2	3	4	5
Chest pain (Please indicate cause, if known ______________________)	0	1	2	3	4	5
Difficulty paying attention	0	1	2	3	4	5
Appetite increased / decreased ←(circle the one which applies)	0	1	2	3	4	5
Binge eating and then throwing up	0	1	2	3	4	5
Weight loss (How much in what time period? ______________________)	0	1	2	3	4	5
Stomach pain or upset	0	1	2	3	4	5
Eating less / eating more ←(circle the one which applies)	0	1	2	3	4	5
Seizures or convulsions	0	1	2	3	4	5
Shortness of breath	0	1	2	3	4	5
Vomiting (not self induced)	0	1	2	[illegible]	4	5
Other problems ______________________	0	1	2	3	4	5

CONTINUED →

MEDICAL HISTORY:

Please list any medications to which your child is allergic ______

Please list anything(s) to which your child is allergic ______

Has your child ever been hospitalized or seriously injured? . . . ☐ No . . . ☐ Yes

Hospital / Injury	Year	Reason / Type of Injury

Please list all medications your child is taking:

Name	Dosage	Times per day	Starting Date	Prescribing physician

Please list all medications your child has taken in the past for emotional or psychological problems:

Name	Final Dosage	Dates (started / stopped)	Prescribing physician

Does your child smoke cigarettes? . . . . . ☐ No . . . ☐ Yes If YES, how many per day? ______

If NO, has he or she smoked in the past? . ☐ No . . . ☐ Yes If YES, date quit: ______

Which close relatives (father, mother, brother, sister, aunt, uncle, etc.) have experienced:

Alcohol abuse ______

Depression / other emotional problems ______

Suicide ______

Drug abuse / dependence ______

Violent or criminal behavior ______

Other problems in living ______

OTHER CONCERNS (Please indicate areas which are impacting your child and/or other members of your family and briefly explain)

☐ Financial problems: ______

☐ Legal problems: ______

☐ Social support: ______

☐ Physical abuse (past or present): ______

☐ Sexual abuse (past or present): ______

Is you child in a special class or program at school? ☐ No ☐ Yes - Please describe ______

Does your child sleep with his or her parents? ☐ No ☐ Yes

WITH WHOM DO YOU LIVE / CURRENT FAMILY (If living alone please list family of origin):

Name	Relationship to you	Age	Gender	Years of Schooling	Occupation	Any problems in living?
			M F			
			M F			
			M F			
			M F			
			M F			
			M F			

RELEASE OF INFORMATION

I, ____ SSN: ______________________
(Client/Parent/Guardian

hereby authorize ____
(Provider of services, title)

To release information pertinent to my condition. The following may be released:

☐ Assessment of condition / diagnosis
☐ Tests pertaining to treatment conditions
☐ History of previous treatment
☐ Goals of present treatment
☐ Date(s) of service
☐ Description and results of treatment
☐ Other ____

This information may be released for the purpose of:

☐ Procuring payment for services from a third party (insurance, EAP, etc.)
☐ Procuring a work excuse or excuse of absence from work or school
☐ Continuity of care to a Primary Care Physician or other provider
☐ Other ____

This information may be released to: ____

____

____

I understand that my record may be protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code 2.1 et seq. (1087), and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

☐ At discharge date, or at date final payment is secured from third party
☐ In thirty days from the date this document is signed
☐ Other ____
(specification of the date, event, or condition upon which this consent expires)

______________________	______________________
Signature	Date
______________________	______________________
Printed Name	Client's Name if Parent/Guardian is signing
______________________	______________________
Witness Signature	Printed Name of Witness

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between behavioral health providers and your primary care physicians is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary.

I, ____________________________, __________ ________________________, for the purpose of coordinating
(Patient Name – Print) (Patient d.o.b.) (Patient Social Security #)

care, authorize____________________________, to release information related to my evaluation and treatment to:
(Provider Name – Print)

PCP Name: ____ **PCP Phone:** ______________________________

PCP Address: ____
(Street) (City) (State) (Zip)

Information For PCP:

The patient was seen by me on (date):______________ for (Diagnosis):__________________________________

Treatment Plan :____

For Psychiatrist's Only:

The following medication(s) was/will be started: (list medications and dosage)_____________________________

____

___ Medication was not indicated ___ Patient refused medication ___ Psychotherapy suggested before trying med.

___I recommend the following medical intervention by PCP before initiating medications:

Medical work-up for:____

Lab tests for: ____ CBC ____ Thyroid Studies ____ Chem Panel ____ EKG
Other: ____

Please call me at ( ) ____________________, to discuss this case further or if you need any other information.

____
(Provider signature) (Provider Printed Name) (Licensure)

CONSENT

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified. I have read and understand the above information and give my consent:

Patient please check one:

( ) To release any applicable mental health/substance abuse information to my primary care physician.
( ) To release only medication information to my primary care physician.
( ) I do not give my consent to releasing any information to my primary care physician.

______________________________________ ____
Patient Signature (Patients over 18) (Date) Parent/Guardian Signature (Patients under 18) (Date)

____
Witness (Date)

Notice To Recipient Of This Information: This information has been disclosed to you from records which are protected by federal (42 CFR Part 2) and state laws regarding confidentiality. Such laws prohibit you from making any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

PROVIDER: Please Send a Copy of this Signed Form to the Primary Care Physician and Keep the Original in the Patient's Treatment Record