CHILD

# Behavioral Medicine Patient Registration

*Please fill out the following information completely*

Patient Name_____ Date _____ Age_____

DOB: _____ Male_____ Female_____ Social Security #_____-_____-_____ (Required)

Mailing Address_____ City_____ Zip_____

Home Address _____ City _____ Zip_____
(If Different from mailing address)

Home Phone: _____ Cell Phone: _____

Race: _____ Decline_____ Ethnicity: Hispanic_____ Non Hispanic_____ Decline_____

Primary Language Spoken_____

Mothers Name _____ Social Security #_____-_____-_____ DOB _____ (Required)

Mothers Employer_____ Occupation_____ Years Employed ____

Employer Address_____ Work Phone # _____

Fathers Name _____ Social Security #_____-_____-_____ DOB _____ (Required)

Fathers Employer_____ Occupation_____ Years Employed ____

Employer Address_____ Work Phone # _____

Primary Physician_____ Phone #_____

Emergency Contact Person _____ Relation_____ Phone _____

Religious Preference (optional) _____ Military Service _____ Referred By_____

## INSURANCE INFORMATION

Primary Insurance Co. _____Insurance I.D. #_____

Name of Policyholder/Sponsor: _____SS#_____-_____-_____D.O.B_____

Employer_____ Group # _____

Secondary Insurance Co. _____Insurance I.D. # _____

Name of Policyholder_____SS#_____-_____-_____D.O.B_____

Employer_____ Group # _____

**Consent and Authorization Affidavit for Child or Dependent Treatment**

According to Part 1.5 (commencing with Section 6550) of Division 11 of the California Family Code, completion of questions below and the signing of the affidavit below are sufficient to authorize enrollment of a minor in psychological care.

Name of minor (print) _____

Minor's date of birth _____

Present or highest grade of education _____

School Name _____

Mother's Name _____

Address_____ City _____ Phone _____

Father's Name _____

Address_____ City _____ Phone _____

Legal parent or guardian (print) _____

***Note: If you are not the parent or guardian, please discuss options with the office staff.***

Parent/guardian address: _____

_____

Parent/guardian date of birth: _____/_____/_____

California Driver's License or ID card # _____

Affidavit

***WARNING: Do not sign this form if any of the statements above are false or you will be committing a CRIME.***

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____ _____

Date Signature

# INITIAL ASSESSMENT QUESTIONNAIRE

Briefly describe why you are seeking treatment today. Please include the Psychological and Social factors and provide a brief history.

What single *specific event* made you seek consultation *today* as opposed to an earlier time?

How long has the chief complaint been present?

What are your medical concerns? Explain below or check None _____

Any Special Status Issues? ☐ Court Mandated ☐ Criminal Family Court ☐ Work Related ☐ Disability ☐

What are the expectations for treatment outcome?

Household Members

| Names | Age | Relationship |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |

Childs Name: _____

# MEDICAL AND BEHAVIORAL HEALTH HISTORY

**Behavioral Health History:**

Has patient been in counseling before? Yes ☐ No ☐
When? Where? How Long? With Whom? Successful? Why Stopped?

For what was the patient being treated? Diagnosis?
Do you want the Therapist to get records? Yes ☐ No ☐

Has patient been hospitalized for a mental health illness? Yes ☐ No ☐
When? Where? How Long?

Is there a history of suicidal thoughts or attempts? Yes ☐ No ☐
Please Explain.

Any history of self-injury? Yes ☐ No ☐

Is there a family history of suicide or homicide? Yes ☐ No ☐

Have any close relatives used medication for mental health? Yes ☐ No ☐

Please mark below any family members who have suffered with mental illness or alcoholism.

| | | | |
|---|---|---|---|
| Biological Father | | Biological Mother | |
| Brothers | | Sisters | |
| Paternal Grandparents | | Maternal Grandparents | |
| Paternal Aunts & Uncles | | Maternal Aunts & Uncles | |
| Paternal Cousins | | Maternal Cousins | |
| | | None | |

Has patient been hospitalized for alcohol or drug abuse/dependency? Yes ☐ No ☐
If yes, please explain. _____

Has patient used: ☐ AA ☐ NA ☐ Other community resources (please list below) ☐ None

_____

## MEDICAL AND BEHAVIORAL HEALTH HISTORY CONTINUED

Does patient use alcohol? Yes ☐ No ☐ How often? How long?

Does patient smoke? Yes ☐ No ☐ How often? How long?

Does patient use caffeine? Yes ☐ No ☐ How often? How long?

Has patient ever had medication prescribed for mental health reasons? Yes ☐ No ☐

Please describe any allergies or bad side effects from previously prescribed medications: or None ☐

Does patient have allergies? Yes ☐ No ☐ Please describe below:

PLEASE LIST ALL CURRENT MEDICATIONS:

| | Medications | Amount | How Often | Reason |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |

Prescribing Physician's Name Address Phone #

Do you want to sign Release Of Information to the M.D.? Yes ☐ No ☐

Medical History:

Are there current medical problems? Yes ☐ No ☐
If yes, please explain. What effect does your medical condition have on your mental health?

_____

_____

**Please check box if you have had or are experiencing any of the following conditions:**

- ☐ **Cardiovascular disease**
- ☐ **Heart disease**
- ☐ **Chest pain or angina**
- ☐ **Swelling of hands, feet or ankles**
- ☐ **Hypertension**
- ☐ **Stroke(s)**
- ☐ **Gastrointestinal disorder**
- ☐ **Frequent diarrhea**
- ☐ **Peptic ulcer**
- ☐ **Endocrine Disorder**
- ☐ **Hormonal change**
- ☐ **Hormone Replacement**
- ☐ **Diabetes**
- ☐ **Colder than before**
- ☐ **Frequent infections or boils**
- ☐ **Skin is becoming dryer**
- ☐ **Thyroid dysfunction**
- ☐ **Genitourinary problems**
- ☐ **Renal (kidney) disease**
- ☐ **Liver disease**
- ☐ **Hepatitis**
- ☐ **Jaundice**
- ☐ **Neurological disorder**
- ☐ **Seizures**
- ☐ **Rendered unconscious**
- ☐ **Concussion or head injury**
- ☐ **Blood disorders**
- ☐ **Malignancy**
- ☐ **Eye disorders**
- ☐ **Glaucoma**
- ☐ **Respiratory problems**
- ☐ **Asthma or wheezing**
- ☐ **None of the above**

Please give details below to the above medical conditions to which you responded, "Yes".

_____

_____

_____

_____

_____

Has there been a recent medical check up, or lab work done? Yes ☐ No ☐
If yes, When? _____

Do you want release of information signed for your medical history? Yes ☐ No ☐

Please mark an "X" in the appropriate box for anyone in the family history who have had any of the following, whether formally diagnosed or not:
**Key:** B=brother;S=sister;F-father;GM=grandmother;GF=grandfather;U=uncle; A=aunt; C=cousin.

| Family Behavior History | | | | Father's Side of Family | | | | | | Mother's Side of Family | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Condition | Self | B | S | F | GM | GF | U | A | C | M | GM | GF | U | A | C |
| Attention Deficit or Inattention | | | | | | | | | | | | | | | |
| Hyperactivity | | | | | | | | | | | | | | | |
| Oppositional Defiance | | | | | | | | | | | | | | | |
| Bipolar | | | | | | | | | | | | | | | |
| Depression | | | | | | | | | | | | | | | |
| Anxiety | | | | | | | | | | | | | | | |
| Social Avoidance | | | | | | | | | | | | | | | |
| Other: _____ | | | | | | | | | | | | | | | |

## Social History

Is patient married or in a current relationship? Yes☐ No ☐
Is the relationship supportive or problematic? Please be specific:

Is patient experiencing any current problems with family members? Yes ☐ No ☐ Please Explain:

Patient's birth order among siblings _____

How was the patient raised?
Natural parents_____ Foster Parents_____ Adopted_____ Intact Family_____
Single Parent Home_____ Parents Separated _____ Divorced _____

Please describe the parental style of your parents. Include events which may be relevant.

Please circle the major stressors in the patient' life from the following:

Health ☐ Finances ☐ Housing ☐ Relationships ☐ Work ☐ Culture ☐ Religion ☐ Ethnicity ☐

Education ☐ Age Related Concerns ☐ Other *(please explain below)*: ☐

Notes:

## CHILD AND ADOLESCENT ASSESMENT:
## PRENATAL, PARINATAL AND DEVELOPMENTAL HISTORY

Fetal health prior to birth:
Was there any exposure to illicit or prescribed drugs? Yes☐No ☐
If yes, please explain the circumstances including type of drugs:
Alcohol _____
Street Drugs _____
Prescription Meds. _____
Tobacco _____
Caffeine _____

Any unusual problems during pregnancy? Yes☐No☐
If yes, please explain: _____
_____
_____

Any complications during delivery? Yes☐No ☐
If yes, please explain: _____
_____
_____

Do you have any concerns about your child's development? Yes☐No☐
If yes, please circle all that apply: *Feeding*☐*Sleeping*☐*Talking*☐*Walking*☐
*Toilet Training*☐*First Word*☐*Transition to School* ☐*Other*-☐please explain:
_____
_____

Does your child suffer from any common or childhood illnesses? Yes☐No☐
If yes, please explain: _____
_____

Has your child had any surgeries or hospitalizations? Yes☐No ☐
If yes, please explain including dates: _____
_____

Have there been any disabilities or functional impairments due to illness? Yes☐No☐
If yes, please explain:_____
_____

Does your child have school learning problems? Yes☐No ☐
If yes, give details: (special education or evaluated for specific learning disabilities)
_____
_____

Describe history of the school learning problem by grade: _____
_____
_____
_____

Does your child have behavioral problems? Yes ☐ No ☐
Does your child have discipline problems? Yes ☐ No ☐
If yes, please explain: _____

Please circle all emotional concerns that apply: *Fears* ☐ *Anger* ☐ *Depression* ☐ *Shy* ☐
*Unmotivated* ☐ *Hyperactive* ☐ *Other* ☐ please explain: _____
_____

Please give a brief history of the above behavioral or emotional problems, including home and school functioning. Include how it has affected elementary, junior high and high school: _____
_____
_____
_____
_____

Does your child have any diagnosed medical problems or allergies? Yes ☐ No ☐
If yes, please explain: _____
_____
_____
_____

Has your child ever been physically, sexually or emotionally abused? Yes ☐ No ☐
If yes, please explain: _____
_____
_____
_____

Does your child have problems with siblings? Yes ☐ No ☐
If yes, please explain: _____
_____
_____
_____

Does your child have any legal difficulties? Yes ☐ No ☐
If yes, please explain: _____
_____
_____
_____

Briefly describe your child's interests and activities: _____
_____
_____
_____

What do you like best about your child? _____
_____
_____
_____
_____

# CHILD SYMPTOM RATING SCALE

Please rate the highest severity and frequency of each symptom listed below during the ***past six months*** for your child by putting an X in the appropriate box to the right as follows:

**0=None (Never) 1=Mild (Sometimes) 2=Moderate (Often)**
**3=Severe (Very Often) 4=Profound (Almost Always)**

| | Symptom Description | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|
| 1 | DEPRESSED/SAD MOOD/SELDOM SMILES | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2 | IRRITABLE/ANGRY MOOD | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3 | LOSS OF INTEREST OR PLEASURE IN THE USUAL THINGS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4 | CRYING SPELLS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5 | EATING PROBLEMS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6 | WEIGHT GAIN OR LOSS* Describe: | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7 | PROBLEMS FALLING OR STAYING ASLEEP | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8 | SLEEPING TOO MUCH | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9 | FATIGUE, NO ENERGY | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10 | FEELINGS OF GUILT OR WORTHLESSNESS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11 | CONCENTRATION PROBLEMS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12 | LOW SELF ESTEEM | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13 | TALKS OF HATING SELF | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14 | HAS THOUGHTS OR TALKS ABOUT DEATH, OR WANTING TO DIE | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15 | HAS HURT SELF OR MADE THREATS TO HURT SELF | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16 | SUICIDE ATTEMPT OR THREAT* Describe: | ☐ | ☐ | ☐ | ☐ | ☐ |
| 17 | WIDE DAILY MOOD SWINGS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 18 | INTENSE RAGES LASTING 30 MINUTES OR MORE | ☐ | ☐ | ☐ | ☐ | ☐ |
| 19 | A FEW DAYS OF HIGH ENERGY | ☐ | ☐ | ☐ | ☐ | ☐ |
| 20 | EXTRA TALKATIVE FOR DAYS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 21 | RACING THOUGHTS FOR DAYS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 22 | INTERRUPTS OTHERS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 23 | DIFFICULTY WAITING HIS/HER TURN | ☐ | ☐ | ☐ | ☐ | ☐ |
| 24 | CAN'T SIT STILL, ACTS AS IF DRIVEN BY A MOTOR | ☐ | ☐ | ☐ | ☐ | ☐ |
| 25 | INATTENTIVE, CAN'T LISTEN OR FOCUS IF IT'S NOT FUN | ☐ | ☐ | ☐ | ☐ | ☐ |
| 26 | TROUBLE FINISHING TASKS; ATTENTION DRIFTS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 27 | ANXIETY, WORRY | ☐ | ☐ | ☐ | ☐ | ☐ |
| 28 | EXCESS WORRY FOR 6 MONTHS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 29 | EXCESS WORRY ABOUT TWO OR MORE DIFFERENT ISSUES | ☐ | ☐ | ☐ | ☐ | ☐ |
| 30 | MUSCLE TENSION | ☐ | ☐ | ☐ | ☐ | ☐ |
| 31 | NIGHTMARES, FLASHBACKS, REPEATED THOUGHTS OF PAST UPSETTING TRAUMAS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 32 | INTENSE REACTION TO SOME REMINDERS OF TRAUMA | ☐ | ☐ | ☐ | ☐ | ☐ |
| 33 | TRYING TO AVOID THINKING OF TRAUMA(S) OR OTHER REMINDERS OF TRAUMA | ☐ | ☐ | ☐ | ☐ | ☐ |
| 34 | NERVOUS, ON GUARD | ☐ | ☐ | ☐ | ☐ | ☐ |
| 35 | FEAR OF HUMILIATION CAUSES FEAR OF BEING WATCHED OR SEEN AND SOCIAL PROBLEMS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 36 | FEAR OF LEAVING HOME, CROWDS, OR LOUD NOISES | ☐ | ☐ | ☐ | ☐ | ☐ |
| 37 | OTHER FEARS AND PHOBIAS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 38 | REPETITIVE ACTS LIKE COUNTING, CHECKING, WASHING | ☐ | ☐ | ☐ | ☐ | ☐ |
| 39 | DISTRESSING THOUGHTS HE/SHE CAN'T GET RID OF | ☐ | ☐ | ☐ | ☐ | ☐ |
| 40 | RESISTS GOING TO SCHOOL | ☐ | ☐ | ☐ | ☐ | ☐ |
| 41 | LEARNING PROBLEMS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 42 | TICS, REPEATED MANNERISMS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 43 | BEDWETTING, SOILING | ☐ | ☐ | ☐ | ☐ | ☐ |

Childs Name: _____

## CHILD SYMPTOM RATING SCALE

Please rate the highest severity and frequency of each symptom listed below during the ***past six months*** for your child by putting an X in the appropriate box to the right as follows: **0=None (Never) 1=Mild (Sometimes) 2=Moderate (Often) 3=Severe (Very Often) 4=Profound (Almost Always)**

| | | | | | | |
|---|---|---|---|---|---|---|
| 44 | HEADACHES | ☐ | ☐ | ☐ | ☐ | ☐ |
| 45 | STOMACHACHES | ☐ | ☐ | ☐ | ☐ | ☐ |
| 46 | BODY WEAKNESS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 47 | SEIZURES | ☐ | ☐ | ☐ | ☐ | ☐ |
| 48 | IMMATURE | ☐ | ☐ | ☐ | ☐ | ☐ |
| 49 | LITTLE INTEREST IN FRIENDS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 50 | VERY UPSET BY CHANGES | ☐ | ☐ | ☐ | ☐ | ☐ |
| 51 | DELAYED SPEECH | ☐ | ☐ | ☐ | ☐ | ☐ |
| 52 | HEARS VOICES | ☐ | ☐ | ☐ | ☐ | ☐ |
| 53 | SEES THINGS NOT THERE | ☐ | ☐ | ☐ | ☐ | ☐ |
| 54 | PROBLEMS AT HOME | ☐ | ☐ | ☐ | ☐ | ☐ |
| 55 | PROBLEMS WITH SIBLINGS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 56 | OTHER SOCIAL PROBLEM | ☐ | ☐ | ☐ | ☐ | ☐ |
| 57 | PROBLEM AT SCHOOL | ☐ | ☐ | ☐ | ☐ | ☐ |
| 58 | FREQUENT TANTRUMS LASTING 30 MINUTES OR LESS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 59 | CONFLICTS WITH ADULTS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 60 | ARGUES, OPPOSITIONAL | ☐ | ☐ | ☐ | ☐ | ☐ |
| 61 | LIES | ☐ | ☐ | ☐ | ☐ | ☐ |
| 62 | DESTROY'S OTHER'S PROPERTY | ☐ | ☐ | ☐ | ☐ | ☐ |
| 63 | STEALS, LEGAL TROUBLE | ☐ | ☐ | ☐ | ☐ | ☐ |
| 64 | LITTLE EMPATHY, CONCERN FOR OTHERS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 65 | CRUEL TO ANIMALS, PEOPLE | ☐ | ☐ | ☐ | ☐ | ☐ |
| 66 | STARTS FIRES | ☐ | ☐ | ☐ | ☐ | ☐ |
| 67 | HARMS OTHERS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 68 | MAKES THREATS OF HURTING OR WANTING TO KILL OTHERS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 69 | IMPROPER SEXUAL BEHAVIOR | ☐ | ☐ | ☐ | ☐ | ☐ |
| 70 | DRUG USE PROBLEM-SELF* Describe: | ☐ | ☐ | ☐ | ☐ | ☐ |
| 71 | DRUG USE PROBLEM-OTHER | ☐ | ☐ | ☐ | ☐ | ☐ |

Has your child ***EVER*** been suicidal or engaged in self-harm behavior?
Check One: ____ **YES** ____ **NO**
If yes, please describe: _____

Has your child ***EVER*** been violent or dangerously aggressive towards others?
Check One: ____ **YES** ____ **NO**
If yes please describe: _____

Please describe the symptoms that most concern you in more detail here: _____

_____ Parent/Guardian Signature

_____ Date

_____ Therapist Signature

## Pain Health and Nutrition Screening

**PAIN SCREENING** Are you experiencing any ongoing physical pain?

Yes No

If NO - No Further questions are required - Go to the next section: Health Screening.

**Location of Pain:**

How would you rate the intensity of the pain on a scale from 1 to 10 with 10 being the worst pain you could imagine?

1 2 3 4 5 6 7 8 9 10

How long have you had this pain?

Are you currently being treated for this pain? Yes No

Is the treatment effective? (A pain rating of 4 or above indicates ineffective treatment)

Yes No

**If not being treated or treatment is not effective, a recommendation and/or a referral should be made for client to see a healthcare provider.*

**HEALTH SCREENING**

Date of last Health and Physical Exam:

Do you have any medical conditions not being treated? Yes No

Do you have any Medical Diagnosis not being treated? Yes No

*If yes to any of the above questions, or the date of the last Health and Physical Exam exceeds 12 months, a recommendation should be made for client to see Primary Health Provider and document recommendation.*

**NUTRITION SCREENING**

Does client have a severe food allergy? Yes No

Food Preferences / Dislikes: Yes No

Special Needs (Texture, Supplements, Cultural/Religious Factors, etc.): Yes No

Does client have a difficulty chewing or swallowing? Yes No

Has the client experienced a decrease in food intake and/or appetite? Yes No

Does the client have eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or inducing vomiting? Yes No

Has the client experienced an unintentional weight loss or gain within the last month (10lbs or more for ADULTS and 5lbs or more for CHILDREN)? Yes No

If Yes to any of the above questions, a recommendation should be made for client to see a healthcare provider on site or referral is to be made.

Dentures: Yes No

Partial Dentures: Yes No

Full Dentures: Yes No

Is the Client currently experiencing Dental Problems? Yes No

If Yes, a referral to a Dentist should be provided.

Patient Name _____

Patient Signature _____Date _____/_____/_____

Therapist Signature _____ Date _____/_____/_____

Name: _____ Date: _____

# Life Events Checklist

(Adapted from the LEC-5)

**Instructions:** Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

| Event | Happened to me | Witnessed it | Learned about it | Part of my job | Not sure | Doesn't apply |
|---|---|---|---|---|---|---|
| 1. Natural disaster (for example, flood, hurricane, tornado, earthquake) | | | | | | |
| 2. Fire or explosion | | | | | | |
| 3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash) | | | | | | |
| 4. Serious accident at work, home, or during recreational activity | | | | | | |
| 5. Exposure to toxic substance (for example, dangerous chemicals, radiation) | | | | | | |
| 6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up) | | | | | | |
| 7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb) | | | | | | |
| 8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm) | | | | | | |
| 9. Other unwanted or uncomfortable sexual experience | | | | | | |
| 10. Combat or exposure to a war-zone (in the military or as a civilian) | | | | | | |
| 11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war) | | | | | | |
| 12. Life-threatening illness or injury | | | | | | |
| 13. Severe human suffering | | | | | | |
| 14. Sudden violent death (for example, homicide, suicide) | | | | | | |
| 15. Sudden accidental death | | | | | | |
| 16. Serious injury, harm, or death you caused to someone else | | | | | | |
| 17. Neglect (e.g., physical, medical, emotional) | | | | | | |
| 18. Exploitation (being taken advantage of for someone else's benefit – financially, sexually, etc.) | | | | | | |
| 19. Any other very stressful event or experience | | | | | | |

# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

THIS AUTHORIZATION TO RELEASE, REQUEST OR DISCLOSE INFORMATION IS TO COMPLY WITH THE TERMS OF THE CONFIDENTIALITY OF MEDICAL INFORMATION ACT 1981, SECTION 56 ET SEQ., OF THE CALIFORNIA CIVIL CODE.

_____ ____/____/____
Patient Name Date of Birth

_____
Address City State Zip

For coordination of care, I hereby authorize the release of information:

☐ TO AND FROM ☐ TO ☐ FROM _____

Yucca Family Medical Care, Inc.
57675 29 Palms Hwy, Suite 111 Yucca Valley, CA 92284
(760) 365-8500 *telephone* (760) 365-5014 *fax*

And my (the patient's) physician: Doctor's Name: _____

Address: _____ Phone: _____

Limits on information disclosure: ☐ None ☐ Limit to _____

-OR-

☐ At this time I do NOT wish to have any information released to my physician.

I understand that I can receive a copy of this authorization upon my request. This authorization may be removed in writing at any time by the undersigned, and if not earlier revoked, shall terminate on:

_____.
*Date or terms*

_____ _____
Signature of Patient Date

_____ _____
Signature of Therapist Date

**Office Policies and Financial Contract with Consent for Treatment**

We want your psychological needs to get the best and most proficient attention possible. A sound relationship between patient and therapist is based on a mutual understanding of these general office policies and the fees and financial arrangements involved. Sessions are by appointment only. After office hours, please leave a voicemail to re-schedule or cancel an appointment.

**Treatment Philosophy**

Outpatient psychotherapy consists of face-to-face contacts between a mental health professional and patient, and may include individual, group, family, short or long term therapy, or crisis intervention. If your contract is with managed care, therapy will be brief and problem focused. You will be expected to participate in setting and achieving treatment goals. A Case Manager oversees your number of sessions and will request information about your therapy. You will be asked to sign a release of confidential information for that purpose.

**Attendance and Cancellation Notice** Regular attendance is necessary to receive the maximum benefit possible from treatment. Appointments are generally 45 minutes long and are reserved for you in our calendar. It is customary and reasonable to require that you give a 24-hour notice for a cancellation of a scheduled appointment. A pattern of failure to keep appointments or failure to give 24-hour notice to cancel may be terms for off-schedule and/ or discontinuation of treatment according to our policy. (Please initial_____).

**Financial Contract, Deductibles, and Co-payments**

You are responsible for obtaining prior authorization from your insurance or managed Care Company prior to treatment. If this office accepts your insurance or we are contracted with your care company, you are responsible for the co-payment amount and the deductible as set by your benefit plan. If for any reason your insurance company does not pay these contracted rates, you will be held accountable for paying your balance. (Please initial_____). Co-payment amounts are set by your benefit plan. These payments are due and payable at the beginning of each appointment. If you desire services not provided by your managed care company or benefits beyond your benefit contract, you will need to sign a separate written contract with this office. (Please initial_____).

**Telephone Calls**

If there should occur a time where essential concerns must be discussed on the telephone, the Provider charges at the same rate as in-person service, based on the amount of time spent on the telephone. These charges will be your personal expense if they cannot be billed to your insurance company. (Please initial_____).

Patient Name_____

**Limits of Confidentiality**

All information and records obtained during the course of treatment shall remain confidential and will not be released without a signed written consent. The legal exceptions to your confidentiality are as follows:

1. If a therapist believes that a patient intends to eminently commit serious bodily harm to another identifiable person or persons, it is the therapist's duty to warn the person or persons of intended harm as well as the authorities (Tarassoff v s. Regents of University of C al., 1976).
2. If a therapist believes that a patient intends to eminently commit serious bodily harm to them self, it is the therapist's duty to take necessary action to protect the individual, which may include notifying authorities (Johnson v. County of Los Angeles, 1983).
3. If a patient becomes involved in certain kinds of very important court cases, a judge may subpoena records and/or testimony. This is rare, but the therapist's ability to shield confidentiality in these cases may be compromised and varies from case-to-case.
4. If a therapist suspects that a child, elder, or dependent adult either i s currently being abused, or has been abused in the past (where t here is a risk of re-offense), and the authorities don't already know about it, it is the therapist's duty to inform the authorities (Welfare & Institution Codes, Penal Codes Section 11165, 11166 and others).

**Releases of Information**

Certain insurance companies (Medicare) and managed care companies ask us to get a release to the primary care physician to coordinate care. You may refuse this request or you can allow it. You will be asked if you wish to sign a release of confidentiality form. If you are electing to use your insurance or managed care benefits, you will be required to sign a release of confidential information to your benefit plan so as to process claims for certification, case management, quality assurance, benefit administration and other purposes such as utilization. If you do not want such information to be shared with your benefit plan, you may pay privately without using your insurance company.

**Consent for Treatment**

I authorize and consent to treatment, which may include various psychological assessment techniques, psychological exams and diagnostic procedures. I understand that while psychotherapy is intended to be helpful, no guarantees as to outcome can be made. The psychotherapeutic process can cause a person to experience unpleasant emotions, feelings and reactions such as anxiety, sadness, and anger. These responses are normal, if they should occur, and I agree to work through these responses with my therapist. I accept and consent to the office policies, financial arrangements, as well as the terms of each of the foregoing paragraphs of this contract.

Patient Name _____

Patient Signature _____ Date _____/_____/_____

Therapist Signature _____ Date _____/_____/_____

# EMERGENCY SERVICES GUIDE

Police/Fire/Ambulance: (24 hours daily) For Medical Emergencies or Hostile Situations: Call 911

San Bernardino County – Sheriff's Department – Morongo Basin Region (760) 366-3781
Morongo Basin Fire Dept. (760) 365-3335

**Hospital**
High Desert Medical Center
6601 White Feather Road, Joshua Tree, CA 92252
760-366-3711

**Crisis Walk-In Center (24 Hour)**
Valley Star Crisis Walk In Center
7293 Dumosa, Suite 2, Yucca Valley, 92284
760-365-2233

**Hotlines**

Suicide Prevention Hotline (24 hours daily):
(800) 273-8255

ACCESS Unit phone number 888-743-1478

Poison Control (24 hours daily):
(800) 876-4766

Child Protective Services (24 hours daily):
(909) 384-9233

Missing Children Hotline (24 hours daily):
(800) 222-3463

Patient's Rights Bureau (24 hours daily):
(800) 440-2391

San Bernardino County Department of Behavioral Health
**24 HOUR ACCESS UNIT**
**(888) 743-1478**

**Hospitals that provide Emergency Psychiatric Assessments (24 hours daily):**
Victor Valley Global Medical Center (760) 245-8691
St. Mary's Medical Center (760) 242-2311
Desert Valley Hospital (760) 241-8000
Barstow Community Hospital (760) 256-1761

Member Safety Plan:

_____

_____

By signing below, I acknowledge that I have received a copy of this document, in addition to the Local Mental Health Plan's Complaint & Grievance Brochure and form, and the Department of Behavioral Health Benefits Guide and handbook.

Client Signature: _____ Date: _____

# EMERGENCY SERVICES GUIDE

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Client Signature: _____ Date: _____

## Acknowledgement of Receipt of *Information* – Advanced Directives

I, _____, hereby acknowledge that I received information about Advanced Health and Mental Health Care Directives as described in the brochures titled "Your Right to Make Decisions about Medical Treatment" and "What Patients Should Know About Mental Health Advance Directives."

I do / do not have an Advanced *Health Care* Directive at this time.
I do / do not have an Advanced *Mental Health* Directive at this time.

_____ _____
Signature of Consumer/Legal Representative Date

---

## Acknowledgement of Receipt of Advanced Directive(s)

I, _____, hereby acknowledge that I have completed a:

- ☐ Advanced Health Care Directive
- ☐ Advanced Mental Health Care Directive

I provided a copy as indicated above to Center Staff.

_____ _____
Signature of Consumer/Legal Representative Date

_____ _____
Signature of Staff Receiving copy of Directive(s) Date

# Acceptance of HIPAA Notice of Privacy Practices

Our full privacy policy is available for your review in the waiting area
You may also request a copy from the front desk to take home with you. It contains important information about ho your confidential health information will be handled by our offices.

I certify that I have been provided access to a copy of the HIPAA Notice of Privacy Practices.

Patient Signature _____ Date _____

Patient Printed Name _____

Yucca Family Medical Care, Inc.
57675 29 Palms Hwy, Suite 111 Yucca Valley, CA 92284
(760) 365-8500 *telephone* (760) 365-5014 *fax*

Welcome,

The state of California request that each client be provided the following notice:

NOTICE TO CLIENTS
The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov or by calling 916-574-7830.

I have read the above notice.

Sign_____

Date_____

## MEDI-CAL REQUIRED INFORMING MATERIALS

Consistent with regulatory requirements stated in the Code of Federal Regulations §438.10 and the California Code of Regulations §1810.360(e) "The MHP of the beneficiary shall provide its beneficiaries with a booklet and provider list upon request and when a beneficiary first receives a specialty mental health service from the MHP or its contract providers."

| | |
|---|---|
| Guide to Medi-Cal Mental Health Services Booklet | ☐ **Provided** ☐ **Offered, but Declined** |
| Provider List | ☐ **Provided** ☐ **Offered, but Declined** |
| EPSDT Pamphlet | ☐ **Provided** |
| Your Rights to Make Decisions about Medical Treatment | ☐ **Provided** |
| Notice of Privacy Practices | ☐ **Provided** |
| Educated on Grievance Process | ☐ **Provided** |
| | |

Signature of Client _____ Date _____

Signature of Parent/Guardian _____ Date _____

Signature of Staff _____ Date _____

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## MATERIALES DE INFORMACIÓN MEDI-CAL

**De conformidad con los requisitos reglamentarios establecidos en el Código de Regulaciones Federales n.o 438.10 y el Código de Regulaciones de California n.o 1810.360(e) "El MHP del beneficiario proporcionará a sus beneficiarios un folleto y una lista de proveedores a petición y cuando un beneficiario primero recibe un servicio especializado de salud mental del MHP o sus roveedores contractuales."**

| | |
|---|---|
| Guia Para Servicios De Salud Mental de Medi-Cal | ☐ **Recibido** ☐ **Ofrecido, pero Declinó** |
| Lista de Proveedores | ☐ **Recibido** ☐ **Ofrecido, pero Declinó** |
| Pamplet de EPSDT | ☐ **Recibido** |
| Sus Derechos a Tomar Decisiones Sobre el Tratamiento Médico | ☐ **Recibido** |
| Aviso de Prácticas de Privacidad | ☐ **Recibido** |
| Educado en el Proceso de Queja | ☐ **Recibido** |
| | |

Firma del Cliente _____ Fecha _____

Firma del padre o tutor _____ Fecha _____

Firma del personal _____ Fecha _____

# Diagnosis Sheet

Client Name: _____ Date: _____ ☐ Initial ☐ Update

**Goal #8 Mental Health**

DSMV/ICD10 _____ ☐ Primary ☐ Secondary ☐ Tertiary

DSMV/ICD10 _____ ☐ Primary ☐ Secondary ☐ Tertiary

DSMV/ICD10 _____ ☐ Primary ☐ Secondary ☐ Tertiary

**Goal #1 Housing issues**

☐ Homelessness Z59.0
☐ Inadequate housing Z59.1
☐ Problems living in a residential institution Z59.3
☐ Living alone Z60.2
☐ Other unsp. housing or economic problem Z59.9
☐ _____

**Goal #2 Financial**

☐ Lack of food and water Z59.4
☐ Extreme poverty Z59.5
☐ Not enough welfare Z59.7
☐ Other unsp. housing or economic problem Z59.9
☐ _____

**Goal #3 Relationship/Communication issues**

☐ Conflict or discord Family Z63.9
☐ Conflict or discord
☐ Partner Relational V61.10 Z63.0
☐ Parent-Child V61.12 Z62.820
☐ Sibling Relational VV61.8 Z62.891
☐ Other relational problem V62.81
☐ Relational Problem NOS V61.81
☐ Other problems related to primary support Z63.8
☐ Problem-primary support group, unspecified Z63.9
☐ Discord with neighbor, lodger or landlord Z59.2
☐ Social Environment Z60.9
☐ _____

**Goal #4 ADLs**

☐ Life Management Z73.9
☐ Lifestyle- eating habits Z72.4
☐ _____

**Goal #5 School/Job**

☐ Occupational problem V62.2 Z56.9
☐ Unemployed Z56.0
☐ Academic problems V62.3 Z55.9

**Goal # 6 Legal issues**

☐ Conviction in civil/criminal no imprisonment Z65.0
☐ Imprisonment and other incarceration Z65.1
☐ Problems related to release from prison Z65.2
☐ Problems related to other legal circumstances Z65.3
☐ _____

**Goal #7 Substance Use**

☐ Alcoholism and drug addiction in family Z63.72
☐ Alcohol Use Disorder F10.10
☐ Opioid Use Disorder F11.10
☐ Unspecified Opioid related disorder F11.99
☐ Cocaine Use Disorder F14.10
☐ Cannabis Use Disorder F12.10
☐ Sedative, Hypnotic, Anxiolytic Use Disorder F13.10
☐ Amphetamine Use Disorder F15.10
☐ Hallucinogen Use Disorder F16.10
☐ Inhalant Use Disorder F18.10
☐ Other Substance Use Disorder F19.10
☐ Nicotine Use Disorder Z72.0
☐ Caffeine Use Disorder F16.10
☐ _____

**Goal # 9**

List specific medical condition affected by lack of care:

_____

_____

# CARE PLAN SIGNATURES

Print Client Name _____

Treatment Plan Date _____

☐ *Annual Care Plan* ☐ *6 Month Review Care Plan* ☐ *Psychiatric Medication Services* ☐ *Additional Care Plan Goal Added*

---

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Provider Signature & Title Date

---

Client was offered a copy of the Consumer Care Plan _____

Date

If Client Signature Absent, see progress note dated: _____

Date

Additional Care Plan Goal added (Goal #_____) _____

Date

# AUTHORIZATION TO BILL INSURANCE

Patient Name: _____ DOB: ____/____/_____

I hereby authorize the release of information:

TO AND FROM

Yucca Family Medical Care, Inc.
57675 29 Palms Hwy, Suite 111 Yucca Valley, CA 92284
(760) 365-8500 *telephone* (760) 365-5014 *fax*

AND

Health Insurance Company: _____

Please read the following declaration then sign and date below where indicated.

I request that payment of authorized medical services furnished to me or my minor child be made by my insurance company, on mine or my minor child's behalf, to the provider of service indicated above. I authorize the medical provider listed above and his agents to release any information concerning my medical care to my insurance company and any of its agents for the sole purpose of determining benefits payable on my medical related charges.

I understand my signature on this form authorizes my insurance company to make payment directly to the provider referenced above and that I am authorizing my provider to release all medical information necessary to adjudicate my medical claims. The patient is responsible for deductibles, coinsurance, in any non-covered services. This policy applies to secondary and subsequent plans as well.

_____ _____

Signature of Patient (Parent/Guardian/Conservator) Date

# Telehealth Services Consent

## Use of Telehealth

Telehealth involves Program staff using technology (internet-connected devices and applications) to video-call you on your internet-connected device (e.g., cell phone, tablet, computer, laptop). Telehealth may be used to provide your assessment and treatment services.

## What is Telehealth and how do Telehealth Services work?

Telehealth services are used when the Program staff cannot be physically present with you to provide assessment and treatment services. Telehealth allows you and the Program staff to talk with and see one another using internet-connected devices and video chat applications.

You will be encouraged to participate in the Telehealth session in a private area with minimal disruptions. You may also request to have a friend or family member present just like during an in-person session. The Program staff will be in a private room at another location with a device that has audio and video ability. Program staff will check to make sure the equipment is working properly and that you and the staff can see and hear one another.

## Telehealth and Confidentiality

We are dedicated to protecting your confidentiality and the security of your medical information (see Client Notice of Privacy Practices). All existing confidentiality protections apply. All existing laws regarding client access to mental health information and copies of mental health records apply.

There is no permanent video or voice recording kept of the Telehealth session. Client identifiable images or information from the Telehealth interaction shall not occur without the consent of the client or as otherwise permitted by law.

We have identified applications that allow us to meet with you through Telehealth which protect your visual and audio communications with us during that process. We will ask you to use these applications which may require you to download an application onto your device. It will ask you to allow it to connect to your device's speakers and camera just while the Telehealth session is active.

In emergency situations (natural disaster, pandemic, crisis) you might request we use another application that we haven't approved. We will do our best to work with you but won't be able to assure the confidentiality of that Telehealth session if a non-approved app is used. We will ask you to acknowledge these risks and we will document in your record that you understood those risks and consent to the use of non-approved Telehealth applications.

## Client Choice

You have the option to withhold consent at this time or to withdraw this consent at any time, including any time during a session, without affecting the right to future care, treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

If you choose not to consent to Telehealth services, the program may be unable to provide you with the convenient and readily available services and services will be rescheduled for a later date and/or a different site.

## Benefits & Risks of Telehealth

I understand that I can expect benefits from Telehealth but that no results can be guaranteed or assured. Telehealth provides me access to medical care that otherwise might not have been available in person. Despite reasonable and appropriate efforts, there is the possibility that:

- The transmission of medical information could be disrupted or distorted by technical failures in transmission;
- The transmission of medical information could be interrupted by unauthorized persons (Note: this risk may be increased if I use a Telehealth application that hasn't been vetted and approved by Stars Behavioral Health Group;
- The electronic storage of medical information generated by telehealth service in one or more databases could be accessed by unauthorized persons;
- Telehealth care, treatment and services may not be as complete as in person care;
- Telehealth does not negate or minimize the risks that may be inherent in a medical/mental illness or condition.

I understand that it is impossible to list every possible risk, that my condition many not be cured or improved, and in rare cases, may get worse.

## Treatment Services

I agree to take part in Telehealth services offered by Valley Star Adult FSP/GMH to receive my assessment and treatment services. Program staff explained and talked to me about the following:

- Telehealth potential risks and benefits
- Confidentiality of Telehealth services
- How the Telehealth service works
- What we'll do if our Telehealth session gets interrupted and our back up plan
- How we'll handle different situations that could come up during the Telehealth session

I have read and agree to all conditions for treatment and Telehealth set forth herein. I acknowledge that I have received a copy of this agreement.

Client: _____ _____

Print Name Signature

Parent/Guardian (if applicable): _____

Staff / Witness _____

For ***verbal consent***, note: _____(date)_____(time).

***Staff shall continue to make efforts to obtain written consent***