AMH Therapeutic Services, LLC

Dr. Asha Madsen-Humeniuk, PsyD, LP
206-280-0388
ashahumeniuk@amhtherapy.com

Informed Consent and Disclosure Statement

Welcome! As an introduction to the therapeutic relationship, please read this document carefully, as it outlines the policies and procedures of my practice, giving you an understanding of what to expect from your treatment, as well as your rights as a client. Feel free to bring up any questions you may have about any of this material.

The Therapeutic Process

In your therapy, you are the expert on you. My goal is to create a safe and supportive environment in which you and I can collaboratively explore any problem areas of your life as well as look at underlying patterns that tend to cause problems to repeat themselves. During the course of therapy, clients sometimes experience a great deal of stress as they tend to very old emotional wounds. This personal growth can be initially disruptive to a client's personal life and relationships as the client re-examines who they are, but it may ultimately lead to a more fulfilling and stable internal life.

In our initial intake session, we will discuss what is bringing you in to therapy. I will try to get a broad picture of how things are going in your life, in terms of social, mental, emotional, and occupational functioning. We will explore what working together might look like, and begin to collaborate on a goal for counseling.

Ongoing therapy sessions last 55 minutes, and can be scheduled weekly or every two weeks. I practice an integrative approach to therapy, which means that I tailor my approach to what you and I find most helpful to you. Sessions tend to be a conversation exploring how things are going in your life, what may need to change, and making sense out of difficult or complicated situations. We may spend time exploring skill-building exercises aimed at communication, emotion regulation, stress management, and other areas. As a client, you have the right to ask questions about or refuse any therapeutic activities at any time.

Education and Background

I am a Licensed Psychologist (LP) in the state of Washington, and have been working in the field of mental health since 2007. I have my Masters (MA) of Counseling Psychology and Doctor of Psychology (PsyD) in Counseling Psychology; both obtained from Northwest University. I have experience working with children, adolescents and adults in both outpatient counseling clinics and school settings. I completed a year of clinical internship at the Puget Sound Psychiatric Center, where I worked with children, adolescents, adults, and elderly facing a variety of issues, including anxiety, depression, life transitions, cognitive disabilities, autism, end of life issues, and others.

I practice an integrative approach to therapy that draws from relational, mindfulness, and existential perspectives, I am also trained in EMDR. I take a collaborative, strengths-based approach to working with clients who are struggling with anxiety, depression, grief, autism, cognitive disabilities, trauma, or facing difficult life transitions.

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I am practicing as an LP (Licensed Psychologist). The Washington licensure law provides complaint and discipline recourse procedures for clients. Inquiries about a mental health professional qualifications and/or treatment practices may be directed to the Washington State Department of Health, Health Systems Quality Assurance, Complaint Intake at P.O. Box 47857, Olympia, WA 98504-7857, or by calling 360-236-4700. My license number is PY61058287.

Length and Termination

Therapy can last anywhere from a few sessions to a few months to a year or more, depending on your specific needs. Short-term therapy can help alleviate immediate here-and-now problems, but may fail to address the underlying patterns or beliefs that cause turmoil to begin with. Long-term therapy has the potential to bring major growth and change, and requires more commitment on the part of the client.

In the infrequent case that I will be absent during your regularly scheduled session, I will notify you as soon as possible, and if necessary, I will make every effort to arrange to have a colleague temporarily substitute in my stead.

Client Rights and Responsibilities

Clients 13 years and older have a right to refuse evaluation and treatment. Clients have a right to change therapists and receive referrals to another therapist. Clients have a right to ask questions about their treatment, about the therapist, the therapeutic approach, and the progress made at any time.

If you are under the age of 18 years, please be aware that the law provides your parents with the right to examine your treatment records, under very rare circumstances, such as an emergency where your safety, or the safety of others is at risk. It is my policy to request an agreement from your parents that, outside of those circumstances, they consent to give up access to your records. If you agree, I will provide them only with general information on how your treatment is proceeding unless I feel that there is a high risk that you will seriously harm yourself or someone else, in which case, I will notify them of my concern. Before giving information, I will discuss the matter with you and will do the best that I can to resolve any objections you may have about what I am about to discuss.

I will write brief case notes summarizing each of our sessions. These notes are part of your confidential record. You have the right to access any of your information, and if you request, I will help you interpret your records in plain English.

Costs

Our initial intake appointment and each subsequent appointment is 55-minutes per session, and costs $200. Fees are to be paid at the beginning of each session. I can accept cash, check, credit, or debit card payments. If you chose to use credit or debit card, there will be a $3.50 transactions fee. I am currently able to accept First Choice, Premera, Anthem, and LifeWise insurance. If you have another insurance plan that you would like to use, I can provide you with a billing statement to submit to your insurance

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company for out-of-network reimbursement. I am happy to provide these billing statements by request. You will need to check with your insurance company to determine your coverage. If the case of outside billing, you are still required to make payment up front for therapy costs, then submit the required documents to your insurance for reimbursement.

If you have a scheduled appointment and need to cancel, I ask that you do so at least 48 hours prior to your appointment. If you do not cancel 48 hours before your appointment, and/or you do not show up for your appointment, you will be charged for that session.

Nature and Limits of Confidentiality

I take your privacy very seriously, both as a professional ethical imperative and as personal courtesy. I will not disclose any information you give me in or out of our session to any third party. There are, however specific legal limits to your privacy; as a legally mandated reporter, I have a duty to report instances of abuse or neglect of children, dependent adults, or elders. I am also bound by legal and ethical codes to break confidentiality in the case of substantial, imminent threats to harm someone, including yourself. When necessary, I will do my best to warn potential victims as well as the proper authorities, such as the police or Child Protective Services. Outside of grave incidences such as these, I will go to great lengths to protect your privacy, and to foster a safe, supportive and trusting environment for your therapy.

Health care providers who are treating the same individual are allowed to share information that may be helpful in that treatment. I also seek consultation with other professionals in order to provide quality service. I make every effort in these situations to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. Unless you object, I will not plan to tell you about these consultations unless I feel it is important in our work together. Psychiatric consultation or other medical consultations may be requested as a part of treatment. In this situation, the patient will be asked to undergo formal consultation with the physician. You are strongly urged to inform your primary physician or your child's physician that you or your child is in therapy. My preference is to obtain your written consent to speak to any other healthcare professional who may be involved in your care, if such care is relevant to our work together.

Alternatives to Treatment

You may decide that therapy is not right for you at this time. If so, I can help you explore options for group therapy, literature on self-help, self-care, emotion regulation, or other alternatives. Maybe you are interested in therapy, but you feel like my counseling style is not a match for your interest and personality, or your specific needs turn out to be beyond the scope of my practice. If so, I'm open to referring you to a counselor whose approach is more in tune with your values.

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Discrimination

I strive to ensure that all of my clients are treated with respect and dignity, regardless of their gender, ethnicity, religion, age, sexual orientation, socioeconomic status, political beliefs, or disability. I try to tailor my therapy with respect to the client's individual history and culture.

Contacting Me

The majority of the time, I will be with clients, and not available to take phone calls. Confidential phone messages and text messages can be left at any time at 206-280-0388. I do my best to respond to messages within 24 hours, with the exception of weekends and holidays. I can also be reached via email (ashahumeniuk@amhtherapy.com); please note that email is not considered a secure form of communication. For your confidentiality, please to not submit sensitive information via email. Due to the limited scope of my practice, I am not able to respond to emergency situations; if you are in crisis, please call the Crisis Line at 206.461.3222. If you are experiencing a life-threatening emergency, dial 911.

Emergency Contacts

Please identify two contacts to be notified in the event of an emergency.

Name		
Relationship		
Primary Phone		
Secondary Phone		

Health Insurance Portability and Accountability Act (HIPAA)

This is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of Protected Health Information (PHI) for treatment, payment, and health care operations. The law requires that I obtain your signature acknowledging that I have provided you these disclosures at the end of this session. A description of the circumstances in which I may disclose information is provided for you. Please review it carefully so you understand fully what confidentiality does and does not mean in the therapeutic relationship. I am happy to discuss any of these rights with you.

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Notice of Privacy Practices

With your signature on the Authorization form I provide, I may disclose information in the following situations:

- Consultation with other health and mental health professionals.
- Disclosures required by health insurers.
- Disclosures required in collecting overdue fees. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, I have the option of using legal means (small claims court) to secure the payment. This requires me to disclose otherwise confidential information. If legal action is necessary, costs are included in claim.
- Court Proceedings (discussed elsewhere in this Agreement).
- Government Agency requests for information in health oversight activities.
- Patient-initiated complaint or lawsuit against me. (I may disclose relevant information regarding that patient in order to defend myself.)
- Patient-initiated worker's compensation claim and the services I am providing are relevant to the injury for which the claim was made. I must, upon appropriate request, provide a copy of the patient's record to the patient's employer and the Department of Labor and Industries.
- If I have reasonable cause to believe a child has suffered abuse or neglect.
- If I have reasonable cause to believe that abandonment, abuse, financial exploitation or neglect of a vulnerable adult has occurred, the law requires that I file a report with the appropriate government agency, usually the Department of Social and Health Services. Once such a report is filed, I may be required to provide additional information.
- If I reasonably believe there is an imminent danger to the health or safety of the patient or any other individual.

Expanded Clinical Records Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include:

- Requesting that I amend your record.
- Requesting restrictions on what information from your Clinical Record is disclosed to others.
- Requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized.
- Determining the location to which protected information disclosures are sent.
- Having any complaints you make about my policies and procedures recorded in your records.
- The right to a paper copy of your signed Agreement, the attached Notice form, and my privacy policies and procedures.
- If any unauthorized breach of Patient information is discovered, you will be notified immediately.

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COMMUNICATION

Based on the new HIPAA Guidelines I am including the following information about the use of cell phones and emails for communication. Please know that I take every precaution to be careful with my cell phone and computer. However, it is important that you know the potential risks involved with confidentiality when using these devices.

Mobile Phone Communication. Please note that if we communicate via my mobile phone by voice or text, your phone number will be stored in the phone's memory for a period of time and therefore if my mobile phone is lost or stolen, it is theoretically possible that your contact information might be accessed. Note that my mobile phone and laptop are password protected, and kept either with me or locked away, providing two lines of defense against such a breach.

Signatures

I have received a copy and fully read and understand the contents of this disclosure statement. My signature below indicates my full consent for treatment. I understand that the fee for a ____-minute session is $_____

_____ _____
Client Date

_____ _____
Parent or Guardian Date

_____ _____
Dr. Asha Madsen-Humeniuk, PsyD, LP Date

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TELEHEALTH (VIDEO/PHONE) COUNSELING AGREEMENT

The purpose of this form is to obtain your consent to participate in tele-mental health, which involves counseling by phone, video, or secure online email portal.

Benefits include:

1. It's more convenient. It can decrease the time commitment of therapy since there is no travel time
2. I can see you even if you are unable to get to my office (ex. transportation issues), if you are home sick, or when you are home caring for an ill family member
3. I can see you when you travel within the state, or even when you move within the state
4. You can always choose to schedule a face-to-face session, when desired

Limitations/Risks include:

1. There is a greater chance of misunderstanding -- due to technology limits, I might not see some of your body language or hear subtle differences in your tone of voice that I could easily pick up if you were in my office. And you might not pick up mine.
2. If we meet in-person, I have more control of interruptions. With video, I can't control your setting.
3. Internet connections could cease working or become too unstable to use
4. The telehealth platform or our computers/smartphones can have sudden failure or run out of power
5. You may feel more emotional distance related to the lack of in-person contact and presence.
6. I cannot guarantee the privacy/confidentiality of conversations held via phone, as these can be intercepted accidentally or intentionally. I cannot guarantee that hackers will not access video calls.
7. I cannot immediately intervene in-person if you are in crisis.

Is it right for you?

Tele-mental health is not a good fit for everyone, so prior to starting telehealth, we will discuss whether it is appropriate for you. If at any point you find the telehealth platform difficult to use or distracting you from our work, please let me know. You have the right to discontinue receiving telehealth counseling at any time, without consequence. I am always happy to discuss moving to phone or in-person sessions. Likewise, if at any point I do not feel telehealth is working for me or for your treatment, I may discontinue this treatment option.

Logistics

1. If we are connecting by video, I will send you a link to sign in to my secure and HIPAA-compatible video platform. You don't need to set up an account of any kind in advance. It is OK to "arrive" early -- I will connect with you at the time of the session. If we are connecting by phone, I will call you at our scheduled time.

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2. I will be in a private location where I am alone in the room. You also need to be in a private location where you can speak openly without being overheard or interrupted by others to protect your own confidentiality. If you choose to be in a place where others can hear you, I cannot be responsible for your confidentiality.
3. At the start of the session, I may verify your location (street address). This enables me to send help, if needed, and to verify that you are in-state. I can only provide therapy to you while you are in the state where I am licensed. If I do not ask, please be sure to tell me if you are not at your home.
4. Do not invite others to join us for any part of the session without discussing this with me in advance.
5. Please be sure to have a cell phone with you or be near a phone, in case video gets cut off.

You may have a better experience if you:

1. Use a computer or tablet instead of a cell phone so that you can see me better.
2. Make sure your device is fully charged.
3. Utilize Chrome or Firefox to connect to the video platform
4. Wear a two-ear headset with microphone (this can help us hear each other)
5. Close other applications or programs on your computer.
6. Make sure you have strong internet connection -- you may need to be near your modem.
7. Consider how you will reduce interruptions (ex. talking to family in advance about your need for privacy during that hour, using a "do not disturb" sign on your door, etc.)
8. Find a location where your face will be well-lit so I can see your facial expressions clearly.

Connection Loss:

- **For video sessions:** If we lose our video connection during our session, please quit and restart your search engine (or computer), and sign in again to the video platform. If you can't reconnect, call my office number (see first page of this agreement), If I do not hear from you within 5 minutes, I will call and email you. I will remain available during the time of our scheduled session, so we can reconnect and continue, if possible.
- **For phone sessions:** If we lose our phone connection during our session, I will call you again from my office phone or an alternate number, which may show up as restricted or blocked -- please be sure to pick up the phone. After 5 minutes if you have not heard from me, you may also attempt to call me at my office number (see first page). I will remain available during the time of our scheduled session, so we can reconnect and recontinue, if possible.
- **Billing for a disrupted session:** If the disconnection is due to my service or equipment, I will not charge you for the session, or will prorate it for what time we talk. If the disconnection is due to your service or equipment, you will be charged in full for the session (not just a copayment).

Best Phone Number to reach you if video or phone connection is lost: _____

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Security

- I utilize video software and hardware tools that adhere to security best practices and legal standards for the purposes of protecting your privacy.
- It is not recommended that you communicate using a public wireless network.
- You represent that you are not using someone else's device or your employer's computer, since employers have the right to monitor their equipment and networks, which could compromise your privacy.
- You have the sole responsibility for security and privacy of your devices, equipment, and internet connection.

Recording of Sessions:

- No sessions will be recorded by me, and the telehealth platform I use states that there is no recording of the session, no information collected, and no digital record saved afterwards. Please note that recording or screenshots of any kind of any session are not permitted, and are grounds for termination of the client-therapist relationship.

Emergencies and Confidentiality:

Since you will be at a distance, please list an emergency contact for you:

_____

Full Name Relationship Phone Number(s)

<u>If you do not expect to be at home for sessions,</u> please give the location you expect you will be:

Street Address_____

If you are outside the area that I practice at the time of our session, I will identify emergency resources in your area and document that in your chart. If you are in crisis and we get disconnected, you agree to call 911, go to your local emergency room immediately or contact the National Suicide Hotline at 800-784-2433 if you cannot reach me.

Please share with me if you have severe feelings of helplessness, hopelessness, or wanting to hurt yourself or others. There are many steps I can take to help, even at a distance. However, if I have extreme concerns about your safety at any time during a phone session, we may need to have you come to the office, or I may need to call your support system or emergency services to keep you safe.

Please note that everything in our informed consent that you signed, including all the confidentiality exceptions, still applies during phone/video sessions.

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Consent to Participate in Telehealth Sessions

By signing below, you agree that you have read and understand all of the above. You give permission for me to communicate with your emergency contact if client is concerned about your safety. You agree that you have had the chance to ask questions, that you understand the limitations associated with participating in telehealth sessions and consent to attend sessions under the terms described in this document.

Signature: _____

Printed Name: _____

Date: _____

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Questionnaire about Insurance to determine Good Faith Estimate need

Information about why you are receiving this form:

According to The Center for Medicare and Medicaid services (https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-ii-interim-final-rule-comment-period)

Good Faith Estimates for Uninsured (or Self-pay) Individuals – Requirements for Providers and Facilities

When scheduling an item or service, or if requested by an individual, providers and facilities are required to inquire about the individual's health insurance status or whether an individual is seeking to have a claim submitted to their health insurance coverage for the care they are seeking. The provider or facility must provide a good faith estimate of expected charges for items and services to an uninsured (or self-pay) individual, meaning an individual that:

- Does not have benefits for an item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, federal health care program (as defined in section 1128B(f) of the Social Security Act), or a health benefits plan under chapter 89 of title 5, United States Code [7],[8]; or

- Has benefits for such items/services under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or a health benefits plan under chapter 89 of title 5, United States Code, but does not seek to have a claim submitted to their plan, issuer, or carrier for the item or service."

Additional information about why you are receiving this form can be found at the following at:

https://www.cms.gov/nosurprises/consumers

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This questionnaire is meant to determine if Good Faith Estimates apply to you.

Client Information

* Client

First name: _____

Middle name: _____

Last name: _____

Date of birth: _____

* Client Contact Information

Street or PO box: _____

City, state, ZIP: _____

Phone number: _____

Email address: _____

Client's contact preference: _____

Insurance Status

* Do you have insurance coverage?

- ☐ Yes, I have a federal coverage such as Medicare
- ☐ Yes, I have insurance privately or through my employer or family member's employer and I plan to pay out of pocket and DO NOT plan submit claims on my own

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- ☐ Yes, I have insurance privately or through my employer or family member's employer and plan to pay out of pocket and I DO plan to submit claims to my insurance carrier independently

- ☐ No, I do not have insurance and I plan to pay out of pocket

* By signing this form, I acknowledge the information I have provided about my insurance status and correct. If it changes, I will notify Dr. Asha Madsen-Humeniuk, PsyD, LP. I understand that if I indicated I do not have insurance or that I DO NOT plan to submit claims myself I have the right to receive further information about a Good Faith Estimate. I understand if I have Medicare or another federally funded program or I have private insurance and DO plan to submit claims Good Faith Estimates do not apply to me.

_____ _____
Client Date

_____ _____
Parent or Guardian Date

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AGREEMENT REGARDING PRIVILEGED COMMUNICITIONS

_____ & _____ hereby agree to the following:

1. _____ & _____ are the parents of: _____ , a minor under the age of 18 ("the minor") who is a patient of Dr. Asha Madsen-Humeniuk, PsyD, LP

2. All communications between the Minor and Dr. Asha Madsen-Humeniuk, PsyD, LP made or that arise in the course of medical treatment are confidential and privileged from disclosure to any and all third persons or entities. The term "communications" includes but is not limited to oral conversations; notes, memoranda, and recordings of oral conversations; documents reflecting medical opinions or evaluations; medical records; and written correspondence.

3. Dr. Asha Madsen-Humeniuk, PsyD, LP shall not be required to testify for any proceedings or in any court any communications that relate to the treatment of the Minor, unless (a) a court competent jurisdiction appoints a Guardian ad Litem to represent the Minor's interests, and the Guardian ad Litem determines by written report that Dr. Asha Madsen-Humeniuk's testimony regarding and/or production of communications relating to the treatment of the Minor is in the Minor's best interests, or (b) otherwise required by the laws of the state of Washington.

AGREEMENT REGARDING PRIVILEGED COMMUNICATIONS
CERTIFICATIONS

FATHER

I certify under penalty of perjury under the laws of the state of Washington that I am the father of _____, a minor. I have read the foregoing Agreement Regarding Privileged Communications, know and understand the contents thereof, and agree to the terms stated therein.

SIGNED this_____ day of _____' 20___, at _____Washington.

_____
(Signature)

_____
(Print Name)

Father of_____

MOTHER

I certify under penalty of perjury under the laws of the state of Washington that I am the mother of _____, a minor. I have read the foregoing Agreement Regarding Privileged Communications, know and understand the contents thereof, and agree to the terms stated therein.

SIGNED this_____ day of _____' 20___, at _____Washington.

_____
(Signature)

_____
(Print Name)

Mother of_____

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Intake Information

Name: _____ Email: _____

Date of Birth: _____ Phone #: _____

Address: _____ ☐ Voicemail ☐ Text

Referred By: _____ Completed By: _____

1. Presenting Problems:

2. Developmental History:

3. Grade/ Name of school if applicable:

4. School Adjustment and Learning:

5. Previous Testing/ Referral Information if applicable:

6. Friendships/ Social Relationships:

7. Family Relationships (include immediate family members, history of learning difficulties, mental illness, etc in family):

8. Psychological and Emotional Functioning (include any safety concerns and any life threatening behaviors):

9. Medical History:

10. Developmental Concerns:

11. Allergies/ Current Medications:

12. Temperament:

13. Life Stressors:

14. Parenting styles:

Child/Adolescent Intake Form

Name: _____ Date: _____

PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today: _____

_____

Please check all your child's behaviors and symptoms that you consider problematic:

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/confusion
- ☐ Sadness/depression
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harm behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self worth
- ☐ Fatigue
- ☐ Recurring, disturbing memories
- ☐ Change in appetite
- ☐ Withdrawal from people
- ☐ Anxiety/worry
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Social discomfort
- ☐ Phobias
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Racing thoughts
- ☐ Wide mood swings
- ☐ Suspicion/paranoia
- ☐ Hearing voices
- ☐ Visual hallucinations
- ☐ Defiance
- ☐ Aggression/fights
- ☐ Homicidal thoughts
- ☐ Frequent arguments
- ☐ Irritability/anger
- ☐ Peer/sibling conflict
- ☐ Stealing
- ☐ Destroys property
- ☐ Running away
- ☐ Swearing
- ☐ Curfew violations
- ☐ Lying
- ☐ Other:_____
- ☐ Manipulative behavior
- ☐ No/few friends
- ☐ Eating problems
- ☐ Sleep problems
- ☐ Nightmares
- ☐ Toileting problems
- ☐ Fire setting
- ☐ Work/school problems
- ☐ Legal problems
- ☐ Sexual behavior
- ☐ Computer addiction
- ☐ Alcohol/drug use
- ☐ Lack of motivation

Are your child's problems affecting any of the following?

- ☐ Handling everyday tasks
- ☐ Recreational activities
- ☐ Self esteem
- ☐ Work/School
- ☐ Relationships
- ☐ Housing
- ☐ Hygiene
- ☐ Legal matters
- ☐ Health
- ☐ Finances

☐ Yes ☐ No Has your child ever had thoughts, made statements, or attempted to hurt him/herself? If yes, please describe: _____

_____

☐ Yes ☐ No Has your child ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe: _____

_____

☐ Yes ☐ No Has your child recently been physically hurt or threatened by someone else? If yes, please describe: _____

_____

☐ Yes ☐ No Has your child gambled in the past 6 months? If yes, let us know the following

☐ Yes ☐ No Has your child ever felt the need to bet more and more money?

☐ Yes ☐ No Has your child ever had to lie to people about how much your child has gambled?

Therapist Notes:

Init: ____

Name: _____

FAMILY AND DEVELOPMENTAL HISTORY

Relationship	Name	Lives with Child?	Age	Quality of Relationship
Mother				
Father				
Stepmother				
Stepfather				
Siblings				
Other relatives				

Family Mental Health Problems	Who?
Hyperactivity	
Sexually Abused	
Depression	
Manic Depression	
Suicide	
Anxiety	
Panic Attacks	
Obsessive-Compulsive	
Anger/Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	

☐ Parents legally married or living together
☐ Parents temporarily separated
☐ Parents divorced or permanently separated

☐ Mother remarried: Number of times _____
☐ Father remarried: Number of times _____

Please check if your child has experienced any of the following types of trauma or loss:

☐ Emotional abuse
☐ Sexual abuse
☐ Physical abuse
☐ Parent substance abuse
☐ Teen pregnancy
☐ Neglect
☐ Violence in the home
☐ Crime victim
☐ Parent illness
☐ Placed a child for adoption
☐ Lived in a foster home
☐ Multiple family moves
☐ Homelessness
☐ Loss of a loved one
☐ Financial problems

☐ Yes ☐ No Were there any medical problems during the pregnancy or birth of your child? If yes, please describe: _____

☐ Yes ☐ No Did the biological mother use any tobacco, medication, street drugs, or alcohol while pregnant with this child? If yes, please describes substances used, quantity, and frequency: _____

_____

☐ Yes ☐ No Did your child have any developmental delays in early childhood (crawling, walking, talking, toileting, etc.)? If yes, please describe: _____

_____

Therapist Notes:

Init: ____

Name: _____

PREVIOUS MENTAL HEALTH TREATMENT

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (mental health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-help/Support Groups			

Therapist Notes:

Init: ____

SCHOOL INFORMATION

Current grade/placement: _____

This year's school grades:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Past school grades:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
This year's school behavior:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Past school behavior:	☐ Excellent	☐ Good	☐ Fair	☐ Poor

Has your child had any of the following difficulties at school?

☐ Suspension ☐ Incomplete homework ☐ Learning problems ☐ Referrals or detentions
☐ Poor grades ☐ Teased or picked on ☐ Speech problems ☐ Attendance problems
☐ Gang influence

☐ Yes ☐ No Does your child have an after-school provider? If so, who? _____

☐ Yes ☐ No Has your child ever repeated or skipped a grade? If yes, which one(s)? _____

☐ Yes ☐ No Has your child ever received Special Education services? If yes, please describe services received and reason for services: _____

What does your child's teacher(s) say about him/her? _____

Therapist Notes:

Init: ____

Name: _____

SUBSTANCE USE HISTORY (for ages 12 and older or if applicable)

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								

☐ Yes ☐ No Has your child had withdrawal symptoms when trying to stop using any substances? If yes, please describe: _____

☐ Yes ☐ No Has your child ever had problems with work, relationships, health, the law, etc. due to his/her substance use? If yes, please describe: _____

Therapist Notes: _____

Init: ____

MEDICAL INFORMATION

Date of last physical exam: _____

Has your child experienced any of the following medical conditions during his/her lifetime?

☐ Allergies
☐ Chronic pain
☐ Dizziness/fainting
☐ High fevers
☐ Miscarriage
☐ Asthma
☐ Surgery
☐ Meningitis
☐ Diabetes
☐ Abortion
☐ Headaches
☐ Serious accident
☐ Seizures
☐ Hearing problems
☐ Sleep disorder
☐ Stomach aches
☐ Head injury
☐ Vision problems
☐ Ear infections
☐ Sexually transmitted disease
☐ Other: _____

Please list any CURRENT health concerns: _____

Current prescription medications: ☐ None

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter medications (including vitamins, herbal remedies, etc.): _____

Allergies and/or adverse reactions to medications: ☐ None
If yes, please list: _____

Therapist Notes: _____

Init: ____

Name: _____

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your child's social support network (check all that apply):
☐ Family ☐ Neighbors ☐ Friends ☐ Students ☐ Co-workers ☐ Support/Self-Help Group
☐ Community Group ☐ Religious/Spiritual Center (which one? _____)

To which cultural or ethnic group does your child belong? _____
If your child is experiencing any difficulties due to cultural or ethnic issues, please describe:_____
_____

How important are spiritual matters to your child? ☐ Not at all ☐ Little ☐ Somewhat ☐ Very much
☐ Yes ☐ No Would you like spiritual/religious beliefs to be incorporated into your child's counseling?

Please describe your child's strengths, skills, and talents? _____
_____
Describe any special areas of interest or hobbies (art, books, physical fitness, etc.):_____
_____

Therapist Notes:

Init: ____

LEGAL INFORMATION

If the parents are separated or divorced, what is the current child custody/visitation arrangement? _____
_____

☐ Yes ☐ No Is your child currently the subject of a custody case?
☐ Yes ☐ No Has your child ever been a ward of the court with SCF/DCFS guardianship?
☐ Yes ☐ No Does your child have any legal offenses on record or pending in the courts?

Therapist Notes:

Init: ____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
TOTAL:				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to sleep or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐