

# Robin Casey MD, PLLC

117 Hidden Valley Dr, Chapel Hill, NC 27516

Ph: (919) 998-6463 Fax: (844) 433-3838

robincaseyemd.com

## Patient Information

**Please print legibly** (circle answers or fill in blanks)

Today's Date: \_\_\_\_\_

**Patient:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_

First Middle Initial Last

Relation: Parent Guardian Spouse Other: \_\_\_\_\_

Street: \_\_\_\_\_

Home: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

**Emergency Contact #2:** \_\_\_\_\_

Cell: (\_\_\_\_) \_\_\_\_\_

(in case of minor, both parents must be listed)

Relation: Parent Guardian Spouse Other: \_\_\_\_\_

Best # to leave a confidential voicemail: Home Work Cell

Home: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Patient Occupation: \_\_\_\_\_

**Address to send statements:** \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Sex: M F Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status:

Single Married Separated Widowed Divorced x \_\_\_\_\_

**Pharmacy:** \_\_\_\_\_

Street: \_\_\_\_\_

**Reason for Appointment:** \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**Referred by:** \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

### Email and Text Appointment Reminders

Email: \_\_\_\_\_ Cell number: \_\_\_\_\_ (our system only allows for one email address and cell number per patient) By signing this section you understand that this is not a guaranteed service and is a courtesy to our patients. **OUR MISSED APPOINTMENT POLICY REMAINS IN EFFECT.** Do not reply to notifications via e-mail or text. To change or cancel an appointment, call the office. You understand that we cannot guarantee the confidentiality of email or text. We will not be liable for improper disclosure of confidential information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

1) **PCP Name:** \_\_\_\_\_

Clinic name: \_\_\_\_\_

Street: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Office: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

3) **Therapist (if applicable):** \_\_\_\_\_

Clinic name: \_\_\_\_\_

Street: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Office: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

2) \_\_\_\_\_

Clinic name: \_\_\_\_\_

Street: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Office: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

4) **Attorney (if applicable):** \_\_\_\_\_

Firm name: \_\_\_\_\_

Street: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Office: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

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## POLICIES & PATIENT AGREEMENT – Page 1 of 2

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### **Please initial each section and provide your signature at the end of the form.**

\_\_\_\_\_ **Appointments:** Due to the sensitive nature of matters discussed and in order for us to give our full attention to the person being evaluated, children may not come to the appointment, unless he/she is the one being evaluated. For patients under the age of 18, all persons with legal, medical decision-making authority should be present for the initial and any following visits. Scheduled appointments are the patient's responsibility to keep track of. Please note that email appointment reminders are a courtesy to our patients and are NOT guaranteed.

\_\_\_\_\_ **General information on prescription refills:** Typically, Dr Casey writes prescriptions for the amount of medication needed until your next scheduled appointment.

Please provide at least **FIVE** business days notice when a refill is needed. We comply with all state and federal laws. Prescription refills for stimulants can only be written every 30 days. We cannot post-date prescriptions. If you use a mail-order pharmacy that is something other than CVS/Caremark or Cigna (they accept electronic prescriptions), please note it is your responsibility to fax in the prescription we provide to you. When requesting a refill, please provide the medication name and dosage as well as the name, full address, and telephone number to your pharmacy. If you are an existing patient and need an emergency refill sooner than five business day, please ask your pharmacy for a refill or ask them for an emergency supply.

\_\_\_\_\_ **Conditions NOT suitable for our clinic:** Adult /Adolescent patients with the following conditions/ situations may not be able to be treated by our clinic and thus may be referred elsewhere for proper care: significant acting out behavior including violence, anger or aggression, to include illegal or criminal behaviors; psychiatric evaluations as required by probation, courts or work-related assessments; patients needing monitoring of injectable medications; any other condition not appropriate as deemed by the physician.

\_\_\_\_\_ **Cell phones, Email Reminders, and Messages:** It may be necessary at times for our office to leave you a message at the phone numbers you provide us. By supplying us with specific phone numbers, you authorize us to leave messages for you at those numbers. By providing your email, you give us permission to contact you in this manner for appointment reminders or general communications. If you are using a cell phone or email while communicating with our office, you must be aware that we cannot ensure the confidentiality of the call or phone/email messages.

\_\_\_\_\_ **Emergencies:** We try to service our patients during a crisis situation whenever possible; however, we are not equipped as a 24-hour emergency facility. In case of an emergency, if you are unable to meet with your provider, call 911 or go to the nearest emergency room.

\_\_\_\_\_ **Missed, Late, Canceled and “No Show” appointments:** As scheduled appointment times are reserved especially for you, all appointments are subject to charge, whether missed, unattended or canceled, unless there has been notice given. In order to avoid being charged \$100 you must call to cancel 24 hours in advance from the scheduled time of your appointment. Insurance companies do not pay for cancellation fees, and therefore, these charges will be your responsibility. **At our discretion, repeated “no show” appointments could result in treatment termination for non-compliance.**

\_\_\_\_\_ **Insurance Verification:** The information you receive when calling your insurance company is not guarantee of payment and your insurance company may or may not pay for services. Once charges are submitted, the insurance company may determine benefits differently that they initially indicated. At any time during treatment should you become ineligible for insurance coverage or should your insurance coverage change you must notify Robin Casey MD, PLLC as soon as possible and prior to your next appointment. You are responsible for payment in full of all services rendered, including services denied or not covered by insurance, or due to failure to obtain pre-authorization of a visit.

(continued on the next page)

## POLICIES & PATIENT AGREEMENT – Page 2 of 2

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\_\_\_\_\_ **Limits of Confidentiality Statement:** All information between practitioner and patient is strictly confidential. There are legal exceptions to this: (1) The patient authorizes a release of information with a signature. (2) The patient's mental condition becomes an issue in a lawsuit. (3) The patient presents as a physical danger to self or others. (4) Child or Elder abuse and/or neglect is suspected. (5) Any official review of the services provided (if you have signed a release authorizing a review, such as insurance forms). In the case of (3) or (4) above, our office is required by law to inform potential victims and legal authorities so that protective measures can be taken.

\_\_\_\_\_ **Consent for Treatment:** I authorize and request my practitioner to carry out evaluations and treatment which now or during the course of my treatment, become advisable. I understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me.

\_\_\_\_\_ **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

\_\_\_\_\_ **Termination of Care by Providers:** I understand that my provider also has the right to terminate care with me. Should my provider choose to terminate care with me, I will be notified in writing or verbally in person or by phone. I understand my provider and/or Robin Casey MD, PLLC / Chatham North Psychiatry will assist me, within reason, in finding a new provider. I understand that if I have not been seen as a patient for a period of two or more years, I will automatically be considered 'terminated'; in this situation I understand I am welcome to reestablish care should I desire to restart care/services.

\_\_\_\_\_ **HIPPA Privacy Practice Notice:** I understand Robin Casey MD, PLLC follows privacy guidelines which are outline in the Notice of Privacy Practices, which has been presented to me and is available at our office at my request.

\_\_\_\_\_ **Payment Responsibility:** Please note if you have a deductible to meet, it is our office policy to collect in full for your appointments until your deductible is met. Any portion of your responsibility of payment (copays/ coinsurance/ deductible) is collected at the time services are rendered. Charges for services which are not benefits of the insurance plan are the patient's responsibility. These may include, but not be limited to: telephone calls to a patient for consultation or medical management; telemedicine (video) appointments; missed appointment fees; preparation of reports for other physicians, agencies, insurance carriers, or attorneys; completion of disability paperwork; medical records.

I understand that I am responsible for payments of all fees charged. I agree to pay for all services rendered, unless my insurance carrier (if I have one) pays for some or all charges. If I have insurance, I agree to make the co-payment for services rendered at the time of each visit. I understand that Robin Casey MD, PLLC will submit any in-network insurance claims for me, including those with or without a co-payment agreement. I understand that if my insurance company denies payment or does not reimburse Robin Casey MD, PLLC for services rendered, or reimburses Robin Casey MD, PLLC differently than they initially indicated, I will be personally responsible for payment.

**By signing below, I certify that I have read and understand these policies and agreements and have full knowledge of its meaning and effect.**

\_\_\_\_\_  
Patient or Parent/Guardian Signature

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Patient or Parent/Guardian Printed Name(s) and relationship to the patient

## Consent for Mental Health Evaluation and/or Treatment

(Child/Teen)

Printed Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**1. Consent to Evaluate/Treat:** I voluntarily consent that my child will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by providers from Robin Casey MD, PLLC / Chatham North Psychiatry. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:

a. The benefits of the proposed treatment, b. Alternative treatment modes and services, c. The manner in which treatment will be administered, d. Expected/potential side effects from the treatment and/or the risks of side effects from medications (when applicable), e. Probable consequences of not receiving treatment. The evaluation or treatment will be conducted by a psychiatrist, psychotherapist, a psychologist, a psychiatric nurse practitioner, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of North Carolina Law for Psychological, Psychiatric, Nursing, Social Work, or Professional Counseling.

**2. Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting my child's daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

**3. Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

**4. Confidentiality, Harm, and Inquiry:** Information from my child's evaluation and/or treatment is contained in a confidential medical record at Robin Casey MD, PLLC / Chatham North Psychiatry, and I consent to disclosure for use by Robin Casey MD, PLLC / Chatham North Psychiatry providers for the purpose of continuity of my child's care. Per North Carolina mental health law, information provided will be kept confidential with the following exceptions: 1) if my child is deemed to present a danger to himself/herself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.



Thank you for taking the time to complete this document. This history form is designed to give you an opportunity to provide us with a wide variety of background information. Please read the questions carefully and answer them as frankly as possible. **The information will help us to help you.** Completion of this form is considered a first step in the evaluation and treatment process. By answering these questions in advance, our staff will be able to spend more time during the initial interview discussing the issues that are most important to you, as you begin mental health treatment. **This information will be used for clinician review.**

**CONFIDENTIAL**  
**FOR PROFESSIONAL USE ONLY**

Date / Time you are completing this form: \_\_\_\_\_

Name of Person Completing this Form: \_\_\_\_\_ Relationship to child \_\_\_\_\_

Phone no's for Person Completing this Form: \_\_\_\_\_

If child has a GUARDIAN, Name: \_\_\_\_\_

Please provide proof of guardianship to the staff to photocopy.

NAME OF CHILD/TEEN: \_\_\_\_\_ DATE OF BIRTH \_\_\_ / \_\_\_ / \_\_\_

SEX: Male \_\_\_\_\_ Female \_\_\_\_\_ CURRENT AGE: \_\_\_\_\_ NICKNAME: \_\_\_\_\_

(STEP)FATHER'S NAME: \_\_\_\_\_ FATHER'S DATE OF BIRTH \_\_\_ / \_\_\_ / \_\_\_

FATHER'S OCCUPATION: \_\_\_\_\_

(STEP)MOTHER'S NAME \_\_\_\_\_ MOTHER'S DATE OF BIRTH \_\_\_ / \_\_\_ / \_\_\_

MOTHER'S OCCUPATION: \_\_\_\_\_

CURRENT ADDRESS: \_\_\_\_\_

(Number, Street, Apt. #)

\_\_\_\_\_  
(City, State)

\_\_\_\_\_  
(Zip Code)

\_\_\_\_\_  
(County of Residence)

PHONE (if different than above): Cell \_\_\_\_\_ Home \_\_\_\_\_

Work \_\_\_\_\_ Other \_\_\_\_\_

(May we phone you at work? Yes \_\_\_\_\_ No \_\_\_\_\_) E-mail: \_\_\_\_\_

CHILD/TEEN'S CITIZENSHIP: \_\_\_\_\_

CHILD'S SOCIAL SECURITY NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

WHAT IS THE FAMILY'S MAIN SOURCE OF INCOME: \_\_\_\_\_

Does the child have a social worker or case manager/name/county? \_\_\_\_\_

MEDICAL INSURANCE (S): (Fill in company names plus policy numbers if they are handy)

What **mental health/psychiatric diagnoses** has your child been given in the past? (ex: depression, bipolar, adhd, etc)

Please list **all medications** (prescriptions, over-the-counter, herbal) he/she is using now, **including dosages and times given**. **Please note if any changes have recently been made to child's meds:**

If he/she has any **allergies or has had bad reactions to medications**, please list them and describe the reaction your child had to each:

**What medications have been tried** for mental health reasons in the past and **why were they stopped** (include as needed medications such as tranquilizers, benzodiazepenes):

How does your child respond to **Benadryl**?      Sleepiness                      More Excited                      No Effect

Who else in the **family** has the following, and if known, what meds have worked well for them:

Depression:
Anxiety:
Bipolar:
Schizophrenia/Schizoffective:

Drug abuse problems (list drugs used):
Alcohol Abuse:
Required mental health hospitalizations:

**Briefly describe the reason(s) why you have come to the clinic today:**

How long has this been a problem? \_\_\_\_\_

Who referred you to our hospital? \_\_\_\_\_

Name of **current PSYCHIATRIST**: \_\_\_\_\_

Date of Last Appointment: \_\_\_\_\_ Date of Next Appointment: \_\_\_\_\_

Name of **current COUNSELOR/THERAPIST**: \_\_\_\_\_

Date of Last Appointment: \_\_\_\_\_ Date of Next Appointment: \_\_\_\_\_

If the child/teen has **ever seen a professional** for this, or for similar problems, please list the former psychiatrists, psychologists, social workers, counselors, member of the clergy, family doctor, etc.,:

	<u>Professional's Name/Address</u>	<u>Dates seen (from ___/to ___)</u>	<u>Problem</u>
1.			
2.			
3.			
4.			
5.			
6.			



If the child/teen has **ever been hospitalized** for psychiatric or medical conditions, please list the following:

<u>Hospital's Name/Address</u>	<u>Dates (from ___/___/___ to ___/___/___)</u>	<u>Problem</u>
1.		
2.		
3.		
4.		
5.		

If the child/teen has had prior mental health treatment, what type of therapy, services, and/or medications did you find to be the **most helpful**?

What **new approaches or services** do you feel would be of the most help to you in caring for your child/teen, if those services are available? (Respite care, in-home therapy, summer programs, intensive case management, outpatient therapy, family therapy, etc.)

Please list the name(s), address(es), and phone numbers of the **family doctor(s) or pediatrician** your child/teen currently uses most often:

Please list the names and addresses of **any other doctors** he/she is seeing/has seen (ex. Neurologist):

- 1.
- 2.
- 3.

Please give the name, address, and phone number of **the drug store you use**:



**FAMILY HISTORY**

<u>Name</u>	<u>Date of Birth or Age</u>	<u>Occupation / Highest School Grade Completed</u>	<u>Lives at home?</u>
Father _____	_____	_____	_____
Mother _____	_____	_____	_____
Bros & Sisters _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please use this space to comment on your child's family while he/she has been growing up, noting any rough spots, such as **parental separation/divorce/remarriage**, and if someone other than his/her natural parents raised him/her, note the name(s):

If he/she has lived in any **foster homes or residential placements**, please list the names and addresses and dates:

Please list the names, ages, and relationships to you of those **currently living with you** and not listed above, including all family members, friends, and so on.

Name	DOB/Age	Relationship	Name	DOB/Age	Relationship

Check any of the following that occurred (or are occurring now) in your family and give a brief description of those checked in the space below:

- |                                     |                                   |
|-------------------------------------|-----------------------------------|
| 1. Physical abuse _____             | 6. Alcohol abuse _____            |
| 2. Violent arguments/fighting _____ | 7. Drug use _____                 |
| 3. Child abuse _____                | 8. Suicidal behavior _____        |
| 4. Sexual abuse _____               | 9. Involvement with a cult _____  |
| 5. Chronic illness _____            | 10. Involvement with a gang _____ |

Details:

Please check what language(s) is (are) spoken and/or written in your home?

English:      \_\_\_\_\_ spoken by parent(s)      \_\_\_\_\_ written by parent(s)

                  \_\_\_\_\_ spoken by child/teen      \_\_\_\_\_ written by child/teen

Spanish:      \_\_\_\_\_ spoken by parent(s)      \_\_\_\_\_ written by parent(s)

                  \_\_\_\_\_ spoken by child/teen      \_\_\_\_\_ written by child/teen

Other Language: \_\_\_\_\_

                  \_\_\_\_\_ spoken by parent(s)      \_\_\_\_\_ written by parent(s)

                  \_\_\_\_\_ spoken by child/teen      \_\_\_\_\_ written by child/teen

**DEVELOPMENTAL HISTORY**

Was the pregnancy with this child/teen full term?      Yes \_\_\_\_\_      No \_\_\_\_\_

If not full term, how long was the pregnancy? \_\_\_\_\_

Please note any complications that occurred during the pregnancy, APGAR scores:

If the mother took any **medications (prescription or over-the-counter) during the pregnancy**, please list them here:

If the mother used **street drugs and/or alcohol during the pregnancy**, please note the type and frequency here:

The birth was:      natural \_\_\_\_\_      caesarean \_\_\_\_\_      labor induced \_\_\_\_\_

Labor lasted:      \_\_\_\_\_ hours      Birth size:      length \_\_\_\_\_      weight \_\_\_\_\_

Please note any complications that occurred following the birth:

Was he/she bottle or breast-fed? \_\_\_\_\_

Developmental milestones (please note the ages, or if all met at normal times just report this):

Crawled      \_\_\_\_\_      Spoke first words      \_\_\_\_\_

Walked      \_\_\_\_\_      Spoke in sentences      \_\_\_\_\_

Weaned      \_\_\_\_\_      Toilet trained      \_\_\_\_\_

**EDUCATIONAL HISTORY**

Highest school grade completed by child/teen? \_\_\_\_\_

Current school, current grade? \_\_\_\_\_

Please list any other specialized education/training/IEP:

Does (did) he/she like school?      Yes \_\_\_\_\_      No \_\_\_\_\_

If he/she has had any **trouble in school with either academic subjects or behavior (including skipping school)**, please describe the problem(s) here:

If he/she has **repeated any grades**, please list them here:

If he/she has received any **special awards or honors** in school, please note them here:

What are **his/her plans, if any, for future education and/or employment?**

**SOCIAL HISTORY**

What does he/she enjoy doing in her/her spare time? (Check all that apply and feel free to add others.)

- |                                                      |                                                          |
|------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> art work                    | <input type="checkbox"/> volunteer work                  |
| <input type="checkbox"/> dancing                     | <input type="checkbox"/> watches TV (How many hrs/day?)  |
| <input type="checkbox"/> drama                       | <input type="checkbox"/> video games (How many hrs/day?) |
| <input type="checkbox"/> computers                   | <input type="checkbox"/> outdoors/nature                 |
| <input type="checkbox"/> cooking                     | <input type="checkbox"/> working on mechanical things    |
| <input type="checkbox"/> listening to music          | <input type="checkbox"/> crafts                          |
| <input type="checkbox"/> playing music/music lessons | <input type="checkbox"/> writing                         |
| <input type="checkbox"/> scouting                    | others: _____                                            |
| <input type="checkbox"/> sports (plays)              | _____                                                    |

What **chores and responsibilities does she/he have** at home? Does the work get done?

If your family actively involved in **church, temple, mosque, or other spiritual activities**, please give the name of this organization and a brief description of the activities:

Does he/she **have friends**?            None                            A few                            Many

Does he/she **make friends** easily?            Yes \_\_\_\_\_            No \_\_\_\_\_

Please provide some information about his/her **past and present relationships with others** and briefly describe any difficulties he/she may have in dealing with people (ex. do they trust others too easily or not enough)?

If he/she is **dating**, please comment upon that here and any **concerns** surrounding that:

Please comment upon **how you discipline him/her** and what seems to work best:

**OCCUPATIONAL HISTORY**

Does he/she have a **job**?    **Yes**            **No**    **How long** has he/she had this job? \_\_\_\_\_

**(If no job ever held and no allowance, please skip to substance use history section)**

If employed, list his/her occupation & employer: \_\_\_\_\_

Please describe the nature of his/her duties/responsibilities and note any recent changes that have been stressful (include promotions, demotions, awards, or any disciplinary actions):

How well does he/she get along with fellow workers? How well does he/she get along with supervisor(s)? If his/her current mental health problems or medications are interfering with job performance, please comment upon that here:

What other jobs has he/she held since he/she began working? Please list any specialized job training:

How does he/she spend, save, and **manage the money earned** through employment? (Include expenses your child/teen is expected to pay for him/herself?

If your child/teen is not employed, does he/she receive an **allowance**? Explain any expenses he/she is expected to pay for him/herself with this money?

**SUBSTANCE USE/ABUSE HISTORY**

If he/she **uses tobacco**, how much and what type is used? Frequency?

If he/she **uses alcohol**, when, where, how much, and what type does he/she drink? Does he/she drink with others or alone?

If he/she has **ever used street drugs** (marijuana, cocaine, LSD, etc.) **or abused prescription medications**, please list the following:

<u>Type of drug</u>	<u>Amount</u>	<u>Frequency</u>	<u>Most Recent Usage</u>
---------------------	---------------	------------------	--------------------------

If he/she has ever been **treated for substance abuse**, please list the name(s) and address(es) of the treatment sites(s):

<u>Name/Address</u>	<u>Dates (From _____ /to _____ )</u>	<u>Problem</u>
---------------------	--------------------------------------	----------------

- 1.
- 2.
- 3.

If he/she consumes **caffeine** (in coffee, tea, colas, etc.), how much is consumed daily?

Does your child/teen have a **history of aggressive behavior**? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Details:

Does your child/teen have a **history of fire setting or playing with fire**? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Details:

Does your child/teen have a **history of hurting animals**? Yes \_\_\_\_\_ No \_\_\_\_\_

If he/she has **ever been arrested or has had legal charges**, please check all that apply:

Juvenile arrest record	Yes _____	No _____
Currently on probation	Yes _____	No _____

If on probation, list the name, address, and phone number of the P.O.:

If applicable, please describe the arrest record here:

Who is aware your child/teen and you are beginning mental health services? (e.g. family, friends, and/or employer) If others are aware, what is their attitude about it?

What **strengths** can you list that will help in resolving the issues you have noted? (e.g., family supports, friendships, personal insights, etc.)

Does the child/teen drive, take buses, or have other **transportation** available?

Please list any times of the day, or days of the week, when you **cannot** make it in to the clinic for appointments:

Please review your answers and, if there is **anything else you feel would be important**, please include it here:

If you are involved with any other agencies/services or you are trying to apply for benefits, please check them off (or add them) below and fill in the name and phone number of the contact person:

<u>Agency/Service</u>	<u>Contact Person</u>	<u>Phone Number</u>
___ Adult Education ( _____ )	_____	_____
___ BHRS - Provider 50 ( _____ )	_____	_____
___ Big Brothers/Big Sisters	_____	_____
___ Children & Youth Services	_____	_____
___ Consumer Organization ( _____ )	_____	_____
___ Drug & Alcohol ( _____ )	_____	_____
___ Family Based MH ( _____ )	_____	_____
___ Foster Care Agency ( _____ )	_____	_____
___ Intensive Case Management ( _____ )	_____	_____
___ Law Suits/Legal Action ( _____ )	_____	_____
___ Public Assistance (or Medical Assistance)	_____	_____
___ Resource Coordination ( _____ )	_____	_____
___ School Counseling or Student Assistance	_____	_____
___ Social Security (e.g. SSD or SSI)	_____	_____
___ Veteran's Administration	_____	_____
___ Support Group ( _____ )	_____	_____
___ Valley Youth House	_____	_____
___ Workman's Compensation	_____	_____
___ Youth Advocates	_____	_____
___ Other ( _____ )	_____	_____
___ Other ( _____ )	_____	_____

Please comment on any of these issues here:

*Thank you for taking the time to fill out this form!*