Child

Osika & Scarano

PSYCHOLOGICAL SERVICES,P.C.

8 Williams Street
Elizabethtown, NY 12932

5 Pine Street
Glens Falls, NY 12801

432 Franklin Street
Schenectady, NY 12305

Telephone (518) 745-0079 **Fax (518) 745-4291** **www.OSPsychServices.com**

INTAKE FORM (Bring with you to scheduled appointment)

PATIENT INFORMATION Date of Birth_____ Age:_____
Patient's Name_____ Sex: M F

Address_____ City_____ State_____ Zip_____

Home Phone #_____ Cell Phone #_____ SS#_____

Referring Physician_____ Primary Physician_____ Referred to this office by: _____

If patient is a minor, PLEASE FILL IN THEFOLLOWING:

Biological Father's Name_____ DOB:_____ **SS#** _____
Address_____ City_____ State_____ Zip_____

Home Phone #:_____ Cell Phone #: _____

Biological Mother's Name_____ DOB:_____ SS#_____
Address_____ City_____ State_____ Zip_____

Home Phone #:_____ Cell Phone #: _____

Legal Guardian Name_____ DOB:_____ SS#_____

Relationship to Patient:_____ Guardian SS#: _____

Address_____ City_____ State_____ Zip _____

Home Phone #:_____ Cell Phone #: _____

Primary **Insurance**:_____ Employer:_____

Subscriber ID#:_____ Group #:_____ Co-pay Amount: _____

Subscriber SS#:_____ Subscriber's DOB: _____

Subscriber's Name _____

Secondary **Insurance**_____ Employer:_____

Subscriber ID#:_____ Group #:_____ Co-pay Amount:_____

Subscriber's SS#:_____ Subscriber's DOB:_____

Subscriber's Name _____

Psychologist Use Only: Diagnosis_____ (Numerical Codes only)

Guarantor, Insured's or Authorized Person's Signature:
I authorize payment of the medical benefits to Osika & Scarano Psychological Services, PC and understand that I am responsible for all balances not covered by my insurance company, such as co-payments, co-insurance, deductibles and non-coverage of benefits. I understand that my co-payment is due at the time of service and if this account becomes delinquent, it may be turned over to a collection agency and the fact that I received treatment in this office will become public record. I understand that there is a $50.00 no show charge if I do not cancel appointments 24 hours in advance. If I do not pay my co-pay at the time of my service date a $10 late fee will be charged. On any balance 6 months overdue, 18% APR and a $50 collection fee will be added.

Parent or Guardian Signature:_____ Date: _____

Parent or Guardian Signature:_____ Date: _____

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Authorization for Treatment of a Minor

I,_____, hereby certify that I am the parent/legal

guardian of the minor child_____, D:O:B:_____, and

that

I have the authority to give consent for his/her mental health treatment. I request and permit that said child shall receive treatment at the above agency and I therefore accept financial responsibility. If there is a change in this consent I must give 30 days' written notice.

I also understand that if I have SOLE LEGAL CUSTODY of the child/patient, I need to provide this office with proof of such a custody arrangement within 14 days of first being seen.

Parent/Guardian: _____

Witness: _____

Date: _____

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STATUS OF LEGAL CUSTODY

If the patient to be seen is under the age of 18, please complete the following. If the patient to be seen is over the age of 18 you are finished completing this packet.

Are the patient's biological or birth parents unmarried or divorced or in the process of a divorce?____YES _____No

If you answered "no", go to next page.

Do you have JOINT LEGAL OR SOLE LEGAL custody of the child (please circle)?

In the case of children with custodial and non-custodial parents, it is SOMETIMES in the child's best interest to notify EACH parent that the child is being brought to treatment. This holds true because during the course of treatment 1) the other non-custodial parent may want to offer information that would otherwise not be received if left out of treatment, 2) the child or yourself may want to address issues with the other non-custodial parent so that they can act more in the child's best interest, or 3) the therapist may want to address issues with the non- custodial so that they can act more in the child's best interest. What follows is a form letter that we prefer (but do not have to) send to non-custodial parents. Please note that only this form letter will be sent which is free of personal and sensitive material. In cases of sole legal custody, you have the right not to consent (to contacting the other biological parent). For parents with joint legal custody no release of information is needed to consult with the other biological parent who has joint legal custody.

Dear_____:

Your child,_____was recently seen at my office for an intake appointment to begin mental health treatment. As a standard part of treatment and because it is your right to know, I prefer to involve both parents, despite the fact that the child's other biological parent made the first appointment. Please call 745-0079 to schedule an appointment at your earliest convenience. Your involvement in your child's treatment is highly recommended and can only help. I hope to hear from you soon.

Sincerely,

Gina Scarano-Osika, Ph.D. and Thomas Osika, Ph.D.

Osika & Scarano

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CONSENT TO RELEASE INFORMATION TO NON-CUSTODIAL PARENT WITHOUT JOINT LEGAL CUSTODY

(to be signed by the custodial parent ONLY IF the custodial parent has SOLE legal custody.)

DOCUMENTATION OF SOLE LEGAL CUSTODY MUST BE PROVIDED AT THE FIRSTSESSION

I,_____, am the biological parent of____
Parent Name
_____
Child Name
and hereby authorize the release of information to_____. The
Non-custodial Parent

Non-Custodial parent's address is_____and his/her phone number is_____. I understand that I need to discuss with Dr. Osika/Dr. Scarano the limits of information to be released.

Signed _____ Date_____
Parent

Signed_____ Date_____
Provider

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INFORMED CONSENT TO CHILD, FAMILY, OR COUPLES PSYCHOTHERAPY

This form documents that we,_____, give our consent to Osika and Scarano Psychological services, P.C. (the "psychologist") to provide psychotherapeutic treatment to us and/or our child. We understand that sometimes it is necessary to conduct family therapy as part of the treatment for our child.

While we expect benefits from this treatment, we fully understand that no particular outcome can be guaranteed. We understand that we are free to discontinue treatment at any time but that it would be best to discuss with the psychologist any plans to end therapy before doing so.

I have fully discussed with the psychologist what is involved in psychotherapy and I understand and agree to the policies about scheduling, fees and missed appointments.

- ***I understand that I am fully financially responsible for treatment, which, if I have health insurance, includes any portion of the psychologist's fee that are not reimbursed by our insurance.***
- ***I understand that the frequency of our sessions will be 1-4 x PER MONTH and that I am fully responsible for payment of all deductibles and co-payments.***
- ***I understand that payment will be due at the time services are rendered.***
- ***I understand that I will be charged $50.00 for any canceled sessions if I do not give the psychologist at least 24 BUSINESS HOUR notice. For example, if I call on 2 pm Sunday to cancel a Monday appointment I will be billed $50.00 (Insurers don't pay for canceled sessions).***
- ***I understand that there will be a $10.00 charge for not paying my co-pay at the time services are rendered.***
- ***I understand that if my bill for services is 30 days past due, I will need to pay the full amount within two weeks in order to avoid interest at the rate of 18%. If payment cannot be made, then I understand that no further appointments will be provided and/or I may be given a referral to see another provider.***
- ***I understand that if my bill is not paid in full within 6 months of the unpaid date of service, in addition to an 18% APR a $50.00 collection fee will be added.***

Our discussion about therapy has included the psychologist's evaluation and diagnostic formulation of our problems, methods of treatment, goals, length of treatment, and information about record keeping. We have been informed about and understand the extent of treatment, its foreseeable benefits and risks, and possible alternative methods of treatment. We understand that therapy can sometimes cause upsetting feelings to emerge, that we may feel worse temporarily before feeling better, and that we may experience distress caused by changes we may decide to make in our life as a result of therapy.

Many providers at Osika and Scarano receive supervision by Dr. Tom and Dr. Gina (the supervisors). We understand that during supervision the patient's name, diagnosis and treatment plan are shared with the supervisors. We also understand that during the course of treatment, pertinent information is shared with the supervisors. As always, all providers abide by privacy policies and HIPAA.

We understand that the psychologist cannot provide emergency service. If an emergency arises we will call the number as follows: Dr.'s Scarano and Osika 744-7978. In any case, we understand that in any emergency, we may call 911 or go to the nearest hospital emergency room. We understand that Glens Falls Hospital has an Emergency Mental Health Staff and they can be reached at 761-5325.

We have received a HIPAA Notice of Privacy Practices from the psychologist. We understand that information about psychotherapy is almost always kept confidential by the psychologist and not revealed to others unless we give our consent. There are a few exceptions as noted in the HIPAA Notice of Privacy Practices. Details about certain of those exceptions follow:

1. The psychologist is required by law to report suspected child abuse or neglect to the authorities.
2. If we tell the psychologist that we intend to harm another person, the psychologist must try to protect that person, including by telling the police or the person or other health care providers. Similarly, if we threaten to harm ourselves, or our life or health is in any immediate danger, the psychologist will try to protect us, including by telling others such as my relatives or the police or other health care providers, who can assist in protecting or assisting us.
3. As per Section 9.46 of the Mental Health Hygiene Law, the psychologist is mandated to report (at https://nysafe.omh.ny.gov) patients who are at imminent risk of harming themselves or others. Such a report could have direct implications as to whether or not I could possess a firearm.
4. If we are involved in certain court proceedings the psychologist may be required by law to reveal information about our treatment. These situations include child custody disputes, cases where a therapy patient's psychological condition is an issue, lawsuits or formal complaints against the psychologist, civil commitment hearings, and court- related treatment.
5. If our health insurance or managed care plan will be reimbursing us or paying the psychologist directly, they will require that we waive confidentiality and that the psychologist give them information about our treatment.
6. The psychologist may consult with other psychotherapists about our treatment, but in doing so will not reveal our names or other information that might identify us. Further, when the psychologist is away or unavailable, another psychotherapist might answer calls and so will need to have some information about our treatment
7. If our account with the psychologist becomes overdue and we do not pay the amount due or work out a payment plan, the psychologist will reveal a limited amount of information about our treatment in taking legal measure to be paid. This information will include our names, social security number, address, dates and type of treatment, and the amount due.

In all of the situations described above I understand that the psychologist will try to discuss the situation with me, or notify me, before any confidential information is revealed, and will reveal only the least amount of information that is necessary.

We understand that, except in exceptional circumstances, the psychologist cannot keep secrets from other family members who are involved in the therapy because this might harm the person who does not know.

We agree that each of us has and shall continue to have the right to information about our individual, family, and/or conjoint treatment sessions, and to the treatment records of the psychologist regarding our individual, family, and/or conjoint treatment sessions. We each agree that the psychologist may release such information

or record to either or all of us without any additional authorization(s) from the other(s). We understand that each of us will not, however, have any right of access to information or records regarding individual treatment sessions of other family members.

We agree that if marriage or parenting problems lead to legal disputes over child custody or visitation, neither of us will ask nor require that the psychologist testify regarding custody or visitation, because to do so would hurt the child's treatment. The psychologist's role is therapeutic and not evaluative. We understand that a third party forensic professional best answers these legal disputes.

If a custody or visitation proceeding does occur, we agree that the psychologist's role will be limited to providing information to a mental health professional appointed to perform a forensic evaluation, the attorneys, law guardian, and/or the judge involved in the legal proceeding. The psychologist will provide these either as required by law or upon our authorization. Because of these limitations, the psychologist also will not be able to give any opinion regarding custody, visitation or any other legal issue.

We understand that we have rights to information about what takes place in the child's therapy, to information about the child's progress in therapy, to information about any dangers the child might present to self or others, and upon request, to obtain copies of the child's treatment record (with certain qualifications and exceptions). We understand that it is sometimes best not to ask for specific information about what was said in therapy sessions because this might break the trust between the child and the psychologist, especially for children over the age of 12. The psychologist has explained to us that children with two parents have the best chance to benefit from therapy if both parents are involved and cooperate with each other and the psychologist. It is best if both the child's parents are consenting to therapy:

- Each of us agrees that he or she will not end the child's therapy without the agreement of theother parent, and that if we disagree about the child's continuing in therapy, we will try to come to an agreement, by counseling if necessary, before ending the child'stherapy.
- We each agree to cooperate with the treatment plan of the psychologist for the child and understand that without mutual cooperation, the psychologist may not be able to act in the child's best interests and may have to end therapy.
- We agree that each of us has and shall continue to have the right to information about the child's treatment and to the treatment records of the psychologist regarding the child, and agree that the psychologist may release information or records to either of us without any additional authorization of the other.

If we and/or the child are participating in a managed care plan, we have discussed with the psychologist our financial responsibility for any co-payments and the plan's limits on the number of therapy sessions. If we and/or the child are not participating in a managed care program, we understand that we are fully financially responsible for treatment, including any portion of the fees not reimbursed by health insurance. The psychologist has also discussed options for continuation of treatment when managed care or healthinsurance benefits end.

We have the right to be notified of a data breach. We have the right to ask for an electronic copy of my medical record. We have the right to opt out of fundraising communications from us. Uses and disclosures of my medical information cannot be sold or used for marketing purposes without my authorization. All patients who pay in full out of pocket for services (i.e. do not bill their insurance) can instruct us to not share information about your treatment with your health plan.

We understand that we have a right to ask the psychologist about the psychologist's training and qualifications. If we ever desire to file a complaint about the psychologist's professional conduct, we understand we can call the NYS Psychology Licensing Board within the Department of Education at 474-3817. Complaints to the licensing board can also be made if you feel your provider or any staff member of Osika and Scarano violates your patient rights or discriminates against you based on gender, race, sexual orientation, national origin or color. If (the licensing board finds that) an employee of Osika and Scarano has violated this non-discrimination policy, appropriate disciplinary action, ranging from counseling to termination, will be taken against the employee who violated the policy.

By signing below, we are indicating that we have read and understand this agreement, that we give consent to the psychologist's treatment for ourselves and/or our child, and that we have the proper legal status to give consent to therapy for our child.

Parent or Guardian Signature:_____ Date: _____

Parent or Guardian Signature:_____ Date: _____

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FEES

For **routine outpatient visits** to our office, we bill your insurance. You are responsible for your copay and deductible (which varies with each plan).

If you **do not have insurance**, please complete the Sliding Fee Scale Packet. In addition, we work closely with a specialist from Fidelis Care, as well as an enrollment specialist from Adirondack Health Institute. Both can help you find a health insurance plan that is affordable for you. We will be more than happy to make a referral for you.

If your insurance does not cover **evaluations for court, probation, etc.**, it will be billed at $300. This includes fees for your sessions and writing of the report.

If your insurance does not cover **achievement testing required to make a diagnosis of a Learning Disability**, you have 3 options:

1) Call your insurance company and ask if they would agree to pay for 2 hours of achievement testing
2) Ask your child's school to complete the achievement testing
3) Have our office complete the testing and agree to pay over a six-month period of time.
    a. If you choose our office to complete the testing, we will administer the Wechsler Individual Achievement Scale. Administration of the WIAT will take about 2 hours and the charge is $60 per hour. A six-month payment plan can be agreed upon in writing at this time.

Unfortunately, most insurance plans do not allow providers to bill for **report writing**. Scoring and writing psychological reports is a daunting task and typically takes 1-3 hours of work. This, again, is billed at a rate of $60 per hour. A six- month payment plan can be agreed upon if needed. Medicaid does allow clinicians to bill for report writing.

Unless you have a specific insurance, there will be a $50 **No Show or Late Cancellation Fee**. We respectfully ask that you give us at least a 24-hour notice prior to cancelling your appointment. However, we understand life happens: you are sick, your car breaks down, or you got called into work. Please keep in mind that No Shows (unless you have a specific insurance) will always be billed, and frequent late cancellations will be billed.

By signing below, you state that you understand and agree to our fee policy.

_____ _____

Client Signature (parent if minor) Date

_____

Name (printed)

Osika & Scarano

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Thomas Osika, Ph.D.
Tacey Shannon, LCSW
Erica Zolinas, LMSW

Amber Shores, LMHC
Christie Seiler, Psy.D.

Gina Scarano-Osika, Ph.D.
Melissa Lehrbach, LMHC
Tekla Rydzewski, MFT-MA

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RELEASE OF INFORMATION/AUTHORIZATION FORMFOR PRIMARY CARE PHYSICIAN

1. I authorize my healthcare practitioner,_____at Osika & Scarano Psychological Services, P.C., and/or administrative and clinical staff to disclose my protected health information, as specified below, to the persons indicated below who will receive the information:

   Primary Care Physician: _____

   _____

   _____

2. I am hereby authorizing the disclosure of the following protected health information:
   DIAGNOSTIC EXAMINATION AND TREATMENTPLAN

3. This protected health information is being used or disclosed for the following purposes:
   To collaborate regarding the treatment plan and diagnosis

4. This authorization shall be in force and affect until one (1) year after the date below at which time this authorization to disclose protected health information shall expire.
5. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to my healthcare practitioner, at Osika & Scarano Psychological Services, P.C., 5 Pine Street Glens Falls. I understand that a revocation is not effective to the extent that my healthcare practitioner has relied on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
6. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by HIPAA or any other federal or state law.
7. My healthcare practitioner will not condition my treatment on whether I provide an authorization for disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____

Signature of Parent or Guardian Date

_____

Print Name of Patient DOB:

(Provide a copy of this form to the patient)

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Refusal to Sign ROI for PCP

<u>ONLY SIGN THIS FORM IF YOU REFUSED TO SIGN THE PREVIOUS PAGE</u>

According to HIPAA, you have the right to refuse giving consent for your provider at Osika and Scarano (O and S) to coordinate care with your PCP. According to your insurance company, however, they require documentation of this refusal and an explanation as to why.

Please put an "x" next to all of the follow reasons why you feel that coordination of care with your PCP is not necessary at this time.

_____ I need to discuss very personal issues that I do not want shared with my PCP

_____ I may consider signing a release at a later date as I gain trust in my provider at O and S

_____ I may consider signing a release at a later date as I discuss the things I do and don't want released to my PCP

_____ I just don't feel it is necessary at this time

_____ Other Explain: _____

_____ _____
Patient Signature Date

_____
Printed Patient Name

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PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

We,_____, assume that we may contact you by telephone at your home and at your work, and in writing at your home, unless you instruct us otherwise.

Under HIPAA, you have the right to request that communications with you be confidential and by means of your selection. We will approve your request if in our opinion it is reasonable. Once we agree to your request, we are obligated to honor it, except if an emergency arises.

I wish to be contacted as follows (check all that apply):

☐ At my home telephone number:_____
- ____You can leave messages with detailed information
- ____Leave message with a call-back number only
- ____Call only at specified times of day:_____

☐ At my work telephone number:_____
- ____You can leave messages with detailed information
- ____Leave message with call-back number only
- ____Call only at specified times of day:_____

☐ At my cell phone number:_____
- ____You can leave messages with detailed information
- ____Leave message with call-back number only
- ____Text message me
- ____Call only at specified times of day:_____

☐ In writing at:
- ____My home address
- ____My work address
- ____My fax number(s):_____
- ____My email address:_____

☐ Other (specify):_____

If any means of contacting you will place you in danger, please specify:_____

_____ _____ _____

Signature of Patient Print Name Date

Osika & Scarano

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Authorization for the Transmission of ePHI

(Electronic Private Health Information)

I have requested that my PHI be transmitted electronically (via email or texting), which I understand is NOT HIPAA Compliant. Since transmitting ePHI is NOT standard procedure at Osika and Scarano, you need to authorize us to send and receive such information electronically. By signing below, you authorize us to send and receive your PHI electronically.

I understand that although the electronic devices and e-mail at Osika and Scarano are password protected, the privacy of my PHI may be breeched by forces beyond our control (e.g. hacking, stolen devices). I understand I should delete any correspondence with our office from my e-mail and phone as soon as possible, which is a standard and customary procedure by all staff at Osika and Scarano. Once signed, this waiver will be in effect until the office is notified in writing.

_____ _____

Patient (Print) Date

_____

Patient or Parent Signature

Osika & Scarano

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PLACE THIS SIGNED & DATED FORM IN ALL CHARTS TO

CONTACT US

This is our contact information as referred to above:

Our Privacy Officers are: Dr. Thomas Osika and Dr. Gina Scarano-Osika

Our mailing address is: 5 Pine Street
Glens Falls, NY 12801

Telephone: (518) 745-0079

Fax: (518) 745-4291

ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge that I have received, read, and understood this Notice of Privacy effective April14, 2003, and that any questions I have about it have been answered.

_____ _____

Signature Date

_____

Print Name

Osika & Scarano

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IMPORTANT NOTICE:

In order to minimize my out-of-pocket expenses, I understand that I am fully responsible for updating this form on a yearly basis and when my insurance changes. Failure to give immediate notice of any change in insurance can result in large out-of-packet expenses, which I will be fully liable to pay in full.

1. Name of Insurance Company _____
(as it appears on the card)
Name of the insurance representative who you got this information from: _____

Date I called: _____

2. Co-pay amount _____

3. Is there a Deductible? _____

4. Referral from Primary Care Physician Needed? _____

5. Outpatient Treatment Report (OTR) needed? _____

If yes, after how many sessions? _____

6. Prior Authorization need? Yes or No If yes, complete the following:

6 a. Authorization Number: _____

6 b. What is the maximum number of visits allowed under this authorization _____

6 c. Is it a calendar year (e.g. 01/01/09 to 01/01/10) _____

If no, give the dates that the authorization is valid from _____ to _____

By signing below, I am agreeing to pay in full any outstanding balance that results from incomplete or inaccurate information.

_____ _____

Patient or Parent Signature Date

_____

Print Name

PSYCHOSOCIAL HISTORY
CHILDREN AND ADOLESCENTS

Name:_____

Parents First &Last Name:_____

Date of Birth:_____

Date of First Session:_____

Who referred your child to this office?_____
Why?_____
Primary Care Physician:_____

In order to better meet your needs during sessions, it is beneficial for the therapist to know some general social history. Please answer the following questions. The more truthful you are, the more beneficial treatment can be for you. For children & teens the questions should be answered as if the child is filling out the form.

Directions: With an "X", please designate which statements are "TRUE" for you.

_____**When I was born, my birth mother was a teen or unmarried**

_____**I was conceived from a sexual assault**

_____**My birth parents remain married**

_____**My birth parents separated when I was years of age**

_____**One or both of my birth parents re-married**

_____**I was adopted. Directions:**

Fill in the blank spaces

I have_____**birth siblings (same parents) of which I am the**_____**born.**

I have_____**half-siblings (share only one birthparent)**

I have_____**step-siblings (children of a step-parent)**

Preg: WNL no substances perinatal stressors or illnesses Pre-natal stressors or illnesses Labor: WNL
Weight: WNL
Illnesses first year: none Developmental Milestones: WNL Physical Development: WNL
Psychological Development: WNL Social Development: WNL Intellectual Development: WNL Academic Development: WNL

Directions: With an "X", please designate which statements are "TRUE" of you.

___ At least one of my childhood mentors (e.g., birth parents, step-parents, grandparents, foster parents) were addicted or overused ALCOHOL.

If "YES", Who? _____

____At least one of my childhood mentors (e.g., birth parents, step-parents, grandparents, foster parents) used ILLEGAL DRUGS.

If "YES" Who? _____

____At least one of my childhood mentors (e.g., birth parents, step-parents, grandparents, foster parents) were PHYSICALLY VIOLENT with each other.

If "YES", Who? _____

____At least one of my childhood mentors (e.g., birth parents, step-parents, grandparents, foster parents) were VERBALLY ABUSIVE with each other.

If "YES", Who? _____
What were their abusive statements/names:_____

_____

____I have been a victim of CHILDHOOD PHYSICAL ABUSE (e.g., at least red marks or bruising)

If "YES", By Whom?_____

____I have been a victim of CHILDHOOD SEXUAL ABUSE (e.g. intercourse OR fondling OR giving OR receiving oral sex)

If "YES", By Whom?_____

____I have been a victim of stranger or date rape.

Directions: With and "X" please designate which statements are "TRUE" of you

I am in_____grade at_____School.

_____I am in Special Education Classes
If yes, describe_____

_____I don't give my full effort on homework.

_____I am frequently tardy or truant from school.

Directions: Fill in the blanks

I have been in_____physically abusive relationships. I have been in

_____verbally abusive relationship.

I have had_____serious relationships end negatively. Describe: _____
Number

_____

_____

_____

_____

_____

_____

Medical illnesses that I currently have: _____

_____

I have had_____periods of unconsciousness in my lifetime.

Prescription Medications that I take daily: _____

_____

_____

I am allergic to these medications:_____

Number of cigarettes I smoke daily:_____

Amount of caffeine I drink daily (coffee, t e a , cola):_____8 oz servings. Number of 8 oz

servings of alcohol I drink weekly:_____

Prescription pain meds I have used in the past six months:_____

Illegal drugs I have used in my lifetime: _____

Illegal drugs I have used in the past 6 months:_____

I have a firearm in my home: yes no
If yes, are the locked in a secure location? yes no

_____

_Directions: With an "X", please designate which statements are "TRUE" of you in the past 6 months. Leave the space blank if the statement does not apply.

_____I have visual memories of abusive childhood events

_____I have nightmares of previous abuse/assaults

_____I cry easily

_____I lose my temper at little things

_____I disobey my parents a lot

_____I blame others

_____I have been stealing

_____I have destroyed things when angry

_____I hurt others when angry

_____I have set fires

_____I have run away from home

_____I have been illegally absent from school

_____I am sexually active

_____I feel depressed most days

_____I feel irritable most days

_____I worry about things I don't think will happen

_____I have difficulty falling asleep

_____I get too little sleep

_____I have trouble staying asleep

------ My appetite has decreased

_____I feel tired most days

_____I require more than 10 hours of sleep

_____I have a difficult time concentrating

_____I feel out of control when I overeat.

_____I avoid some foods (e.g., fatty or high in sugar).

_____I am unhappy with my weight and body shape.

_____I've had thoughts of killing myself in the past

_____I have wanted to die in the past.

_____I have had a planned method of killing myself

_____I have hurt myself on purpose by cutting, burning or bruising myself.

_____I have tried to kill myself in the past

If "Yes", When_____

How_____

_____I have been hospitalized for psychiatric reasons

If "YES" Where?_____

When? _____

_____

_____I have been placed on psychiatric medications in the past.
If yes, which ones_____

_____I am currently taking psychiatric medications.
If yes, which medications and how much_____

_____I have seen a mental health professional for outpatient treatment in the past.
Describe previous treatment provider's interventions:_____
_____

_____Did treatment help you in the past

_____Members of my family have mental illness.
If yes, which illnesses:_____
_____
_____

(Patient Stop Here and skip next page)

Mental Status Examination:

Patient came to interview with_____. Parent was cooperative and understood her/his privacy rights under HIPAA.
Parent was appropriately concerned about patient.
Insight: WNL DENIAL Empathy:
ADEQUATE Judgment: ADEQUATE

Patient is a year old Caucasian who appeared stated age. Patient was weighed upon intake and they stood
_____feet tall and weighed_____giving them a Body Mass I n d e x of . Patient was
_____motivated for therapy and was cooperative. Mood
DFA DSA
Appetite Psychosis: None
Insight: WNL Judgment:
WNL
Patient Denied SI/HI

DSM-V DIAGNOSTIC IMPRESSIONS:

1)

2)

3)

4)

5)

TREATMENT GOALS:

Patient will be seen for individual therapy. Object-relational, cognitive-behavioral, brief time limited and family systems interventions will be utilized in order to meet the follow goals within 10 to 15 sessions:

A release of information will be signed in order for treatment to be coordinated with patient's pediatrician/family physician and to discuss the utilization of psychiatric medications.

_____