

**NORTHEAST OHIO BEHAVIORAL HEALTH, LTD.  
REGISTRATION FORM**

**CLIENT INFORMATION**

**DATE:** \_\_\_\_\_

Client Name \_\_\_\_\_ Soc Sec. # \_\_\_\_\_

Address: Street \_\_\_\_\_ Phone # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Occupation (even if currently unemployed) \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Major source of income (employment, unemployment, welfare, etc.) \_\_\_\_\_

Race: Asian    Black/African Amer.    Native Amer./Amer.Indian    White    Unknown  
Ethnicity: Puerto Rican    Mexican    Cuban    Other Hispanic    Not Hispanic or Latino

**GUARANTOR INFORMATION** (Party responsible for charges not covered by insurance)

\_\_\_\_\_ Same as Above

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

\_\_\_\_\_ D.O.B. \_\_\_\_\_

**INSURANCE INFORMATION**

Primary:

Name of Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Birthdate \_\_\_\_\_

Relationship to Client \_\_\_\_\_ Effective Date \_\_\_\_\_

Address: Street \_\_\_\_\_ Phone # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Secondary:

Name of Insurance Company \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Relationship to Client \_\_\_\_\_ Effective Date \_\_\_\_\_

Other:

Medical Assistance Program \_\_\_\_\_ 12 Digit Medical Assistance Number \_\_\_\_\_

Is this a Workman's Compensation Case?    Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes: Name of Attorney: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Does insurance require precertification for treatment? \_\_\_\_\_

**(over)**

**AUTHORIZATION FOR RELEASE OF INFORMATION:**

I Hereby authorize Northeast Ohio Behavioral Health, LTD to release such information in connection to my treatment to the above named insurance company(ies) for the purpose of processing the insurance claim.

**GUARANTEE OF ACCOUNT:**

I understand I am financially responsible for charges not covered by this authorization.

**ASSIGNMENT OF INSURANCE BENEFITS:**

I hereby authorize payment of the benefits otherwise payable to me by the designated insurance companies directly to Northeast Ohio Behavioral Health, LTD. The amount not to exceed regular charges.

**PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED**

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Client (parent, if minor – guardian – legal representative)

Signed \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

**REMINDER CALLS:**

In order to provide our clients with appointment reminder calls, NEOBH requires written permission from the client/parent or guardian.

I would like an appointment reminder call \_\_\_\_\_  
(Signature)

Phone numbers: (1) \_\_\_\_\_ (2) \_\_\_\_\_

It is permissible / not permissible for NEOBH to leave a message.

Leave message \_\_\_\_\_  
Signature

DO NOT leave message \_\_\_\_\_  
Signature

**NORTHEAST OHIO BEHAVIORAL HEALTH, LTD.  
FEE AGREEMENT FORM**

- Diagnostic Assessment/Initial Intake Interview - \$140 per 45-60 minutes session.
- Individual Counseling - \$99.99 per 45-60 minute session, \$60.00 per 20-30 minute session.
- Group Counseling - \$45 per person per hour.
- Specialized Services/Evaluations/Assessments – fees vary and are explained under a separate document which will be presented if applicable.
- Fees for reports, testing, letters, summaries, telephone consultations and other services will not be billed to Insurance, Medicaid or most third party payers and are therefore your financial responsibility.
- There will be a \$25 charge for checks returned for non-sufficient funds.
- **We reserve the right to charge for your visit if there is not a 24 hour notice of cancellation.** This will not be billed to Insurance, Medicaid or third party payers and is therefore your financial responsibility. Additionally, we reserve the **right to refuse to provide future services** should you demonstrate a history of no shows and/or late cancellations.
- **Deductible and co-pay amounts, in addition to those services not covered by another payer, are due at the time of each visit.**
- Although we may bill your insurance company and/or third party payer, **you are ultimately responsible for payment of services rendered, and for contacting your insurance company and/or third party payer if payment is not received in a timely manner.**
- If your bill for services rendered is not paid promptly, we may find it necessary to turn your account over to a collection agency. We will make every effort to avoid this by working with you to ensure timely payments on your account. However, if it does become necessary to turn your account over to a collection agency, we reserve the right to charge an additional collection fee.
- For your convenience, we accept Visa, MasterCard, Cash, Personal Checks and Money Orders.

I have read and fully understand the above provisions. I give permission to and request that Northeast Ohio Behavioral Health, Ltd. bill my Insurance, Medicaid or any third party payer for services rendered to me or to a member of my family. I clearly understand that it is still my responsibility to make sure that the bill is paid in a timely manner. If, for any reason, any portion or the entire bill is not paid by Insurance, Medicaid or any third party payer, I agree to make arrangements for prompt payment to Northeast Ohio Behavioral Health, Ltd.

**\*REQUIRED INFORMATION FOR ALL CLIENTS:** Family Income: \$ \_\_\_\_\_ per month Family Size: \_\_\_\_\_ persons

\_\_\_\_\_  
Signature of Client or Parent/Guardian

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of NEOBH Representative

\_\_\_\_\_  
Date Signed

## MACSIS RESIDENCY VERIFICATION

The purpose of this form is to clarify which county is responsible for adjudicating claims for behavioral health services provided to the client being enrolled. It should be completed and provided to the enrolling board when:

- The county of the treating facility does not match the legal county of residence of the client as noted on the enrollment form (child or adult, out-of-county).
- The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client (example: domestic violence shelter case, client temporarily living with relatives, child or adult, out-of-county).
- The child's physical address as noted on the enrollment form does not match the legal custodian's address (child only, in or out-of-county).

A client's or legal custodian's signature on this form shall be sufficient for documenting residency with the exception of adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories referenced in the residency guidelines.\*

### Adult

<b>Client is an adult?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, complete the following information.</b>	
Client Name (please print)	
Street Address for Residency Determination Purposes	
City, State, and Zip for Residency Determination Purposes	
Signature of Client	Date

### Minor

<b>Client is a Minor?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, indicate if child is in legal custody of the following (this is not the foster parent).</b> <input type="checkbox"/> Parent <input type="checkbox"/> CSB <input type="checkbox"/> DYS <input type="checkbox"/> Court <input type="checkbox"/> Other (specify): _____
Client Name (please print)	
Name of Legal Custodian Marked Above	Phone No. of Legal Custodian
County of Legal Custodian	
If Parent, Address of Parent (if different from client's physical address on enrollment form)	
Signature of Legal Custodian	Date

\*For the special exceptions noted, this form should not be used. Refer to the residency guidelines for more information on how to determine residency in these cases and/or what documentation is needed to provide proof of residency.



NORTHEAST OHIO BEHAVIORAL HEALTH, LTD.

**Authorization for Disclosure of Confidential Information and/or Enrollment into the Multi-Agency Community Services Information System (MACSIS)**

To be eligible to receive public funds to help pay for the cost of your services, we must provide information to the Mental Health and Recovery Services Board of Stark County and/or to the Agency/Board in your county of residency.

The information must be provided in order to:

- Enroll you in your residing counties plan
- Determine what public funds can be used to pay for your services
- Pay NEOBH through a system connected with the Ohio Department of Mental Health, Ohio Department of Alcohol & Drug Addiction Services, and the Ohio Department of Job and Family Services

ALL INFORMATION COLLECTED WILL BE KEPT CONFIDENTIAL, consistent with State and Federal law. All uses for the information collected are described in NEOBH's HIPAA Privacy Practices Policy.

\_\_\_\_\_  
Signature of Client or Parent/Legal Guardian

\_\_\_\_\_  
Date

**Northeast Ohio Behavioral Health, Ltd.**

**PERMISSION FOR TREATMENT**

I hereby authorize Northeast Ohio Behavioral Health, Ltd. to provide \_\_\_\_\_

Client's Name

with the following services:

- \_\_\_\_\_ Individual Psychotherapy
- \_\_\_\_\_ Psychological Testing/Evaluation/Assessment
- \_\_\_\_\_ Family Counseling
- \_\_\_\_\_ Custody Evaluation
- \_\_\_\_\_ Parent Consultation
- \_\_\_\_\_ CPST – Community Psychiatric Supportive Treatment
- \_\_\_\_\_ Other \_\_\_\_\_

I understand that mental health services sometimes carry a risk of undesirable side effects and am aware that I am entitled to an explanation of such possible side effects. I further understand that only those services listed above will be provided unless I give signed authorization for additional services.

\_\_\_\_\_  
Signature of Client or Parent/Legal Guardian

\_\_\_\_\_  
Relationship to Client (if under 18)

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

**Client Rights, Civil Rights and Grievance Procedures:**

I have received a copy of Northeast Ohio Behavioral Health, Ltd.'s Client Rights, Civil Rights and Grievance Procedures. I understand that I can ask any questions that I may have about these policies, at any time.

_____ Signature of Staff Member	_____ Signature of Client/Parent/Guardian	_____ Date
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**Privacy Practices Policy:**

I have received a copy of Northeast Ohio Behavioral Health, Ltd.'s Notice of Privacy Practices. I understand that I can ask any questions that I may have about these policies, at any time.

_____ Signature of Staff Member	_____ Signature of Client/Parent/Guardian	_____ Date
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Northeast Ohio Behavioral Health, Ltd.

PRIMARY CARE PHYSICIAN COMMUNICATION FORM

Client: Please fill out the data in the box only and sign at the "X". Thank You!

Client's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Primary Care Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Check here if client does not have a Primary Care Physician.

Authorization to Disclose Information

I understand that my records are protected under the applicable state law governing healthcare information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in regards to it. This release will automatically expire twelve (12) months from the date signed.

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_  
(Print Client's Name) (Print Treating Clinician's Name)

To release any applicable information TO my Primary Care Physician (as listed above).

NOT to release information to my Primary Care Physician (as listed above).

To receive the following information FROM my Primary Care Physician (as listed above):

\_\_\_\_\_

X \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_  
Signature of Client or Guardian Date

\*\*\*\*\* Office Use Only \*\*\*\*\*

Dear Dr. \_\_\_\_\_:

Your patient, \_\_\_\_\_, was recently seen in our office for outpatient counseling. We hope that the following information will help in coordinating this patient's care. Please call if further information would be helpful.

Date of initial consultation: \_\_\_\_\_ Date of next appointment: \_\_\_\_\_

Diagnosis and brief description of presenting problem(s): \_\_\_\_\_

\_\_\_\_\_

Treatment Recommendations: \_\_\_\_\_

Treating Clinician's Name: \_\_\_\_\_

Address/Phone:

2795 Front Street, Suite A; Cuyahoga Falls, OH 44221; 330-945-7100.

4510 Dressler Rd. NW; Canton, OH 44718; 330-494-5155.

213 Market Avenue N., Suite 200; Canton, OH 44702; 330-494-5155

Sincerely,

\_\_\_\_\_

Clinician's Signature

**Northeast Ohio Behavioral Health, Ltd.**

**SUPERVISION DISCLOSURE STATEMENT**

Dear Client:

Your therapist, \_\_\_\_\_, is a (circle appropriate title):

- Psychology Assistant
- Professional Counselor
- Pre / Post-Doctoral Psychology Trainee
- \_\_\_\_\_

who is being supervised by (circle appropriate Supervising Psychologist/Supervisor):

- Robin Tener, Ph.D.
- Aimee Thomas, Ph.D., P.C.C.-S
- Gail Mager, P.C.C.-S.
- Leah Schilling, L.P.C.C.-S
- Name of Supervisor: \_\_\_\_\_ Credentials \_\_\_\_\_

Treatment services provided to you may include Intake Evaluation/Diagnostic Assessment, Individual, Group, Family or Conjoint Counseling, and Psychological Testing. Through methods such as the taping of treatment sessions, review of psychological testing data, review of notes of treatment sessions and discussion of the content of treatment sessions, your therapist will receive supervision that will enable him/her to develop important skills. Supervision of your therapist will enable Northeast Ohio Behavioral Health, Ltd. to ensure that you are receiving the best possible treatment services.

Confidentiality is important at NEOBH. Both your therapist and his/her supervisor are bound by specific State and Federal laws, as well as by professional ethics that govern confidentiality. Any information that may be recorded within a counseling session is strictly confidential, is used only for training, and is erased when training is completed. Detailed information about confidentiality can be found in the Client Rights and HIPAA Privacy Rules materials that are provided to each client/guardian during the initial appointment. Please note that all therapists at NEOBH follow relevant laws regarding the duty to report suspected child abuse, or imminent harm to another person.

You have already received information regarding the financial policies of NEOBH. If we are billing insurance, bills will be submitted under the name of our agency and/or under the name of the Supervising Psychologist/Supervisor. In either case, it will be clear who provided the billed service.

The Supervisor is ultimately responsible for the services that are provided by your therapist. You may request a meeting with your therapist's supervisor before, during or following your treatment. If you have concerns about your treatment, please contact the supervisor at the following numbers:

- Dr. Robin Tener: (330) 945-7100 or (330) 494-5155
- Dr. Aimee Thomas: (330) 494-5155
- Gail Mager, P.C.C.-S.: (330) 945-7100 or (330) 494-5155
- Leah Schilling, L.P.C.C. (330) 945-7100
- Supervisor: \_\_\_\_\_ Phone: \_\_\_\_\_

Any additional concerns regarding your treatment at Northeast Ohio Behavioral Health, Ltd. may be reported to Dr. Robin Tener, Executive Director, at (330) 945-7100 or (330) 494-5155.

I have read the above and understand the nature of the supervisory procedures. I recognize that I can ask any questions regarding supervisory issues, and may speak to my therapist's supervisor. I consent to having my counseling sessions taped for the purposes of supervision.

Client's Name: \_\_\_\_\_ Client's/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_ NEOBH Representative's Signature: \_\_\_\_\_

Date: \_\_\_\_\_ NEOBH Supervisor's Signature: \_\_\_\_\_



### CHILD/ADOLESCENT BACKGROUND INFORMATION FORM

Childs Name (First, MI, Last)			Date of Birth		
Name of Person Completing Form			Relationship to Child		
<b>Living Situation</b>					
Parent's Home	<b>OR**</b>				
<input type="checkbox"/> Rent	<input type="checkbox"/> Relative's/Guardian's Home	<input type="checkbox"/> Friend's Home	<input type="checkbox"/> Foster Care Home		
<input type="checkbox"/> Own	<input type="checkbox"/> Homeless in Shelter/No Residence	<input type="checkbox"/> Respite Care	<input type="checkbox"/> Other:		
**Identify Person's Name or Facility:					
<b>Primary Household</b>					
Household Members Name(s)	Relationship to Client	Age	Occupation/School	Level of Education	How does client get along with this person?
Street Address (if different from client's address on Registration Form):					
<b>Secondary Household</b>					
Does Client live in more than one household?					
<input type="checkbox"/> YES If Yes, complete the secondary household information below.					
<input type="checkbox"/> NO If No, skip this section.					
Household Members Name(s)	Relationship to Client	Age	Occupation/School	Level of Education	How does client get along with this person?
Street Address (if different from client's address on Registration Form):					
Family Members Who Live in Both Households					
<input type="checkbox"/> Only Client <input type="checkbox"/> Client and (list):					
<b>Custody and Parenting Plan/Family Environment</b>					
<input type="checkbox"/> Lives with Both Parents (biological or adoptive in Same Household or with Widowed Parent					
<input type="checkbox"/> Other (describe):					
Are you involved in a church or do you practice a religion?					

<b>Developmental Issues</b>	
List any developmental problems or health problems the child had during:	
Mother's Pregnancy:	
Infancy (age 0-1):	
Preschool (age 2-4):	
Childhood (age 5-12):	
Adolescent (age 13-17):	
Sexual Issues/Concerns:	
<b>School Functioning</b>	
Regular Education Classroom, No Special Services:	
<input type="checkbox"/> YES <input type="checkbox"/> NO   If No, check all that apply.	
<input type="checkbox"/> Multiple Disabilities (not deaf-blind) <input type="checkbox"/> Orthopedic Impairment <input type="checkbox"/> Autism <input type="checkbox"/> Deaf-Blindness <input type="checkbox"/> Emotional Disturbance (ED) <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Deafness (hearing impairment) <input type="checkbox"/> Developmental Handicap DH <input type="checkbox"/> Current 504 Plan <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Specific Learning Disability <input type="checkbox"/> Other: <input type="checkbox"/> Speech or Language Impairment <input type="checkbox"/> Preschoolers with a Disability	
Grade:	Name of School:
Comments about School or Grades:	
School Proficiency/Achievement Exams/Ohio Graduation Tests (OGT)	
Most Recent Exams: Grade Level: ____ <input type="checkbox"/> OGT (reading and math only) <input type="checkbox"/> Has Not Taken Exams	
Exams Taken	Results
Reading	<input type="checkbox"/> Passed <input type="checkbox"/> Did Not Pass <input type="checkbox"/> Unknown
Math	<input type="checkbox"/> Passed <input type="checkbox"/> Did Not Pass <input type="checkbox"/> Unknown
Citizenship	<input type="checkbox"/> Passed <input type="checkbox"/> Did Not Pass <input type="checkbox"/> Unknown or N/A
Science	<input type="checkbox"/> Passed <input type="checkbox"/> Did Not Pass <input type="checkbox"/> Unknown or N/A
Writing	<input type="checkbox"/> Passed <input type="checkbox"/> Did Not Pass <input type="checkbox"/> Unknown or N/A
Other Test Results (IQ, achievement, developmental)	
Attendance - Number of days missed in past 3 months:	
Previous Grades Failed/Repeated	
<input type="checkbox"/> None <input type="checkbox"/> Grade(s):	
Discipline Record	
<input type="checkbox"/> Suspensions/Expulsions:	
<input type="checkbox"/> Other Academic/School Concerns:	
Peer Relationship/Social Functioning	
Special Communication Needs	
<input type="checkbox"/> None <input type="checkbox"/> TDD/TTY Device <input type="checkbox"/> Sign Language Interpreter <input type="checkbox"/> Assistive Listening Device(s) <input type="checkbox"/> Language Interpreter Services Needed/ Other Spoken Language:	

<b>Family Environment/Relationship</b>				
<b>Parent-Child Relationship(s)</b>				
Parent-Child Conflict:	<input type="checkbox"/> None-Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	
Parent Supervision of Child:	<input type="checkbox"/> Always	<input type="checkbox"/> Usually	<input type="checkbox"/> Inconsistently	<input type="checkbox"/> Rarely
Cooperation Between Parents Regarding Child-Rearing:	<input type="checkbox"/> Always	<input type="checkbox"/> Usually	<input type="checkbox"/> Inconsistently	<input type="checkbox"/> Rarely
Parent Positive activities with Child:	<input type="checkbox"/> Frequent	<input type="checkbox"/> Occasional	<input type="checkbox"/> Infrequent	
Parent Satisfaction with Relationship:	<input type="checkbox"/> Satisfied	<input type="checkbox"/> Neutral	<input type="checkbox"/> Dissatisfied	
Child Satisfaction with Relationship:	<input type="checkbox"/> Satisfied	<input type="checkbox"/> Neutral	<input type="checkbox"/> Dissatisfied	
Comment on Parent-Child Relationship (describe further if needed):				
<b>Sibling-Child Relationship(s)</b> <input type="checkbox"/> No Siblings				
Child-Sibling(s) Conflict:	<input type="checkbox"/> None-Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	
Sibling(s) Positive activities with Child:	<input type="checkbox"/> Frequent	<input type="checkbox"/> Occasional	<input type="checkbox"/> Infrequent	
Sibling(s) Satisfaction with Relationship:	<input type="checkbox"/> Satisfied	<input type="checkbox"/> Neutral	<input type="checkbox"/> Dissatisfied	
Child Satisfaction with Relationship:	<input type="checkbox"/> Satisfied	<input type="checkbox"/> Neutral	<input type="checkbox"/> Dissatisfied	
Comment on Sibling-Child Relationship(s) (describe further if needed):				
<b>Parent Marital or Couples Relationship(s)</b> <input type="checkbox"/> Not Applicable				
Marital or Couples Conflict:	<input type="checkbox"/> None-Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	
Marital or Couples Satisfaction:	<input type="checkbox"/> Satisfied	<input type="checkbox"/> Neutral	<input type="checkbox"/> Dissatisfied	
Comment on Parent Marital or Couples Relationship(s) (describe further if needed):				
<b>Other Family Concerns</b>				
Family Member Alcohol Abuse:	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate:	<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling <input type="checkbox"/> Other
Family Member Substance Abuse:	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate:	<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling <input type="checkbox"/> Other
Family Member Mental Health Problem:	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate:	<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling <input type="checkbox"/> Other
Family Member Health Problems:	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate:	<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling <input type="checkbox"/> Other
Family Member Disabled:	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate:	<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling <input type="checkbox"/> Other
Family Member Legal Problems:	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, indicate:	<input type="checkbox"/> Parent	<input type="checkbox"/> Sibling <input type="checkbox"/> Other
Family Financial Concerns:	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Other (describe):				
Comment on Other Family Concerns or problems that impact child:				
<b>Medical Issues</b>				
Health Issues/Medical History (include any allergies and food/drug reactions):				

<b>Mental Health Treatment History</b>					
Outpatient Mental Health Treatment <input type="checkbox"/> None (skip this section)					
Agency	Check if Current	Past (Date)	Clinician Name		
Psychiatric Hospitalizations/Residential Treatment Facilities <input type="checkbox"/> None					
Facility	Date of Service	Reason (suicidal, depressed, etc.)			
Previous or Current Diagnoses (if known):					
<b>Current Medication Information</b> (prescription/OTC/herbal) <input type="checkbox"/> None					
Medication	Reason for Taking Medication	Dosage/Route/Frequency	Is It Helping?		
			Yes	No	Unsure
Prescribing Physician(s):					
<b>Past Medications for Mental Health Problems</b> <input type="checkbox"/> None					
Medication	Reason for Discontinuation				
<b>Alcohol/Drug History</b>					
<input type="checkbox"/> Client has no alcohol/drug history (skip this section)					
Illegal drug use/abuse past 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes      Non-prescription drug abuse? <input type="checkbox"/> No <input type="checkbox"/> Yes					
Prescription drug abuse past 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes      Alcohol abuse past 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes					
If Yes, please explain:					
Drug/Substance/Alcohol	Age of First Use	Date of Last Use	Frequency of Use	Amount	
<b>Alcohol/Drug Treatment History</b>					
<input type="checkbox"/> Client has not received alcohol/drug treatment (skip this section)					
Name of Provider Agency	Type of Service	Date of Service			

<b>Problem Checklist</b>	
What Problems is the Child/Adolescent Having?	
Check	Check All Current Problem Areas, Please Explain:
	<b>Nutritional/Eating Pattern Changes</b>
	<b>Pain Management</b>
	<b>Depressed Mood/Sad</b>
	<b>Grief/Loss Issues</b>
	<b>Anxiety</b>
	<b>Distressing/Disturbing Life Events – Recent or Historic</b>
	<b>Anger/Aggression</b>
	<b>Oppositional Behaviors</b>
	<b>Problems Paying Attention/Concentrating</b>
	<b>Sees or Hears Things That Other People Do Not</b>
	<b>Mood Swings/Hyperactivity</b>
	<b>Substance Use/Addiction</b>
	<b>Other Addictive Behaviors (i.e. Food, Internet)</b>
	<b>Sleep Problems</b>
	<b>Wetting/Soiling Self</b>
	<b>Difficult Circumstances at Home or at School</b>
	<b>Other:</b>
Signature of Person Completing Form:	Date:
Therapist's Signature:	Date: