

**Child New Patient Intake Form (online fillable)**

**Below is the intake paperwork for Empowering Choices Counseling & Consultation. We understand that this is a long packet and that some of our questions are in-depth, and we understand they may, at times, ask for personal information, but it is intended to be an all-inclusive look at you as a person. Our intent is to collect as much information as we can about you in-order-to provide the best counseling services we can for you. If there are questions that you do not feel comfortable answering or would rather talk with your counselor about, please mark “Will talk to my counselor about”. Please return the paperwork to your counselor on your initial session.**

| **Client Name:** |  |  |
| --- | --- | --- |
| **Today’s Date:** |  | **Date of Birth:** |
| **Age:** | **Gender:** | **Street Address:** |
| **City:** | **State:** | **Zip Code:** |
| **Phone (Cell):** |  | **Other Phone:** |
| **May we leave messages for you?** | **Cell: Yes ☐ No ☐** | **Other Phone: Yes ☐ No ☐** |
| **Preferred Contact E-Mail Address:** |  |  |
| **Emergency Contact Name:** |  | **Relationship:** |
| **Emergency Contact Phone Number:** |  |  |
| **How did you hear about us?** |  |  |

| Correspondence: |
| --- |
| Can we mail correspondence to this address? Please Initial: ☐ Yes ☐ No |
| May we call and leave a message on your cell phone? Please Initial: ☐ Yes ☐ No |
| May we call and leave messages on your other phone? Please Initial: ☐ Yes ☐ No |
| May we contact you by email? Please Initial: ☐ Yes ☐ No |

*Empowering Choices Rates for Services, Policies & Procedures*

| **Type of Service** | **Cost** |
| --- | --- |
| Mental Health Therapy and Assessments;  Personal, School, or Behavioral Consultation;  Case Management | $250 for a 50 minute session with a Licensed Professional Counselor.    $200 for a 50 minute session with a Professional Counselor Associate.    $150 for a 50 minute session with a Masters-level student-intern. |
| Subpoenaing your counselor | Same hourly fee as counselor’s therapy rate |
| Group Therapy | $75 per hour |
| Seminars | Regular Rate: $200 per hour for a group of 6 and under; $30 per person per hour for a group of 7 or more.    Non-profit discount rate available |
| Not Sufficient Funds Check fee – Returned Checks | $30 per check plus any bank charges we are billed.  Must be paid with cash or card |
| Functional Assessment | $400-800 |
| Copies of paperwork where applicable | .15 per page |

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**Informed Consent Information**

*The following statement expresses the current policies and procedures of this office. Please read it carefully and if you have any questions, ask your counselor for additional information and/or clarifications.*

# Your health record contains personal information about you.  This information may identify you as it relates to your past, present or future physical and/or mental health condition(s) and related healthcare services.  This information is commonly referred to as Protected Health Information (PHI). Please understand that any information we obtain or receive is only to assist our client in their growth and healing through the counseling process. This Notice of Privacy Practices describes how Empowering Choices Counseling and Consultation (ECCC) may use and disclose your PHI in accordance with state and federal law which includes the Health Insurance Portability and Accountability Act (HIPAA) regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.

# **Our Obligations:** ECCC is required by State and Federal law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. ECCC is required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices and Informed Consent information at any time. Any new Notice of Privacy Practices and/or Informed Consent information will be effective for all PHI that we maintain at that time. The revised Notice of Privacy Practices and/or Informed Consent Information will be updated on our website or a copy can be requested by you to be sent to you or provided at your next appointment.

**Uses and Disclosure:**

ECCC may use and disclose protected health information without your consent in the following ways:

* Child Abuse or Neglect
* Judicial and Administrative Proceedings
* Deceased Patients (with your prior signed consent)
* Abuse of and elderly or vulnerable adult
* Medical Emergencies
* To those you give consent too. Such as: friends and family also involved in your treatment.
* Law Enforcement (but only absolutely necessary information to the emergency)
* Health Oversight Agencies
* Public Health (preventing, treating, or controlling diseases)
* Public Safety
* Verbal Permission (once you have given it and to be followed by a signed release)
* Other members of our clinic team for consultation

# **Professional Ethics and Accountability:**

# Empowering Choices Counseling and Consultation is a community of clinicians with a mission to provide compassionate and competent counseling services to children, adolescents, individuals, couples, and families. We are a group of professionals, most of which are pre-licensed professionals, who practice according to the state board Code of Ethics. We encourage you to ask any further questions concerning our academic preparation, counselor training, professional credentials, theoretical orientations, case consultation, clinical supervision, or continuing education.

**Treatment Risks and Alternatives:**

Please be informed that there are risks involved in the counseling process. For example, some people experience an increase in stress, especially during the early stages of treatment. In some cases, a discussion of long-standing unresolved issues can seem to aggravate rather than alleviate a problem. These are natural occurrences of which you need to be aware. While we cannot guarantee the success of our outcomes, we nonetheless intend and attempt to provide you with the highest possible quality of care. If we determine we cannot provide treatment to meet your personal or particular needs, your counselor will inform you at the earliest opportunity and assist you in finding more appropriate services.

In addition to providing direct services, Empowering Choices Counseling and Consultation offers clinical training, experience, and supervision to post-graduate residents pursuing their professional credentials. Occasionally, these counselors will require recordings of their clinical work with clients to serve their educational needs. Accordingly, your counselor may ask your permission to record a session. Please allow your personal discretion to inform your consent. If you feel hesitant to give permission, speak with your counselor about your reluctance, or simply say “I would rather not.” Recordings are subject to our strict policy of confidentiality, are used exclusively to assist supervisors in helping counselors to develop their clinical skills and are destroyed immediately following their use in supervision.

**Legal Issues and Proceedings:**

Our mission includes helping children, adolescents, individuals, couples, and families resolve their psychological, spiritual and relationship conflicts through the counseling process; rather than providing them advocacy, evaluation, or testimony in the judicial system (see legal preceding below). If you need a forensic assessment or a clinician who will testify in court, we will attempt to assist you in finding a provider who offers those services.

**Legal Proceedings:**

**As clinicians, we understand that we may be called into court to testify at times. When we are called to testify, we are bound by ethics to answer things honestly. This does not mean that your clinician’s testimony will be solely in your favor. In many ways our hands are “tied” to answering the specific questions of the prosecution and defense. We are not allowed to freely advocate for our clients as we would and could do in other situations such as: with doctors, schools, other professionals, etc. We can only testify to the facts of a case and not to our professional opinion. Due to these specific limitations, as a general rule, we discourage you from having your therapist subpoenaed into court. If and when we are subpoenaed, we do charge for the time we have to move other clients or block out times within our schedule to travel too and appear in court (See our rate of pay chart above). In addition to our general rate, clients may be responsible for all attorney fees and costs incurred by the therapist as a result of the legal action.**

**Office Hours:**

Office hours are by appointment only. Appointments are approximately 50 minute sessions and begin promptly at the appointed time. Each clinician primarily keeps control of their own appointments and availability.

**Initial Sessions:**

Your first appointment will be a fifty (50) minute session with one of our counselors. The counselor will review the information you shared when you called for your appointment, listen to your concerns and assess your needs, answer any of your questions, and plan with you how to proceed. You may decide mutually to work together, be referred to another clinician at Empowering Choices Counseling and Consultation or be referred to another person or agency in the community for appropriate assistance.

**Fees**:

The standard fee for service at Empowering Choices Counseling and Consultation is $150.00- $250.00 per session, depending on the clinician. If you need an adjusted fee based on your ability to pay, please ask your counselor for a copy of the Fee Adjustment Scale which is our sliding scale.

**Payment Policy:**

Our policy is to receive payment in full at each session unless you make arrangements with your individual counselor. Please make checks payable to Empowering Choices Counseling and Consultation, pay in cash with exact change, or pay online through our website.

**Insurance:**

ECCC is currently credentialed as an In-Network-Provider with several insurance companies such as: Regence Blue Cross/ Blue Shield, Moda, Providence, and Oregon Health Plan (OHP). As we are working to continually be credentialed into other insurance companies, this list may continually grow. Check our website under “Insurances”.Although our clinic may not be set up directly with other insurance companies, a large number of insurance companies will work with us as what is referred to as: **Out of Network Providers** on several different levels. On our website, under “payments” we explain how to talk to your insurance company to see if they will allow us to bill them for our services. Some insurance plans do reimbursements or allow you to use health savings plans. Please check with your insurance company prior to your appointment. We will be happy to do what we can in talking with your insurance company; however, you are responsible for keeping current with payments.

**Cancellation Policy:**

Our policy is to charge a $40 fee for all cancellations and missed sessions that are under 24 hours except in the case of occasional emergencies. We feel that in under 24 hours, the $40 will cover the clinicians struggle to fill their time slot. Our company feels that a cancellation over 24 hours gives the clinician a fair amount of time to fill the time slot on their own which helps us keep the lights on.

**End of Services:**

Your status as a client with Empowering Choices will automatically end 30 days after our last contact. Additionally, you or your counselor may end the relationship earlier as needed. If you owe Empowering Choices more than $300, we reserve the right to stop counseling sessions until the balance is paid.

**Communicating with your Counselor:**

Electronic communication such as emails and texts have risks in their use. They can potentially be intercepted and read by others who you do not want seeing them. Empowering Choices cannot guarantee but will use reasonable means to maintain the security and confidentiality of email, phone, voicemail, and text information sent and received. ECCC is not liable for improper disclosure of confidential information that is not caused by the provider's intentional misconduct.

Your counselor may communicate with you about some subjects such as scheduling through email or text. However, complex information should not be communicated through email or text. Please call and/or schedule an appointment to discuss complex and/or sensitive information. Electronic information and messages received and sent may be printed and filed in your record.

**Social Media:**

Your counselor will not communicate with you via social media systems such as Facebook and Twitter and you are not expected to "like" or "follow" any social media accounts of Empowering Choices or our staff. You are not expected to leave us positive reviews anywhere online. If you have concerns about our services, please reach out to us. We would be happy to address your concerns to the best of our abilities. We believe connecting with clients on social media would compromise your confidentiality and potentially negatively impact the counseling relationship.

**Internet Searches:**

It is our policy to not search out information about you on the internet using systems like Google. In the case of an emergency, we may attempt to find out information using the internet if it relates to your health and safety.

**Letter Writing:**

If you request a written letter from your counselor for accommodations or other needs, your counselor will take your request into consideration. We will discuss your request with you and determine if it is within our scope of practice, ethics, and training to be able to write the letter you request. We will not be able to accommodate all letter writing requests and writing a letter may incur an additional expense per our fee schedule above. Insurance companies may not cover the writing of accommodation letters.

**Emergency Procedures:**

Empowering Choices Counseling and Consultation is not a crisis response facility. **In the event of an emergency—defined here as an imminent danger to yourself, others or both—please call 9-1-1 for immediate assistance.**

**Support Services:**

All functions concerning billing and payment, insurance reimbursement, case documentation, and other support services are provided with the same concern for professionalism and quality. In order to protect your confidentiality, a written authorization will be required for the release of information. A service fee may be charged for duplication, summarization, and other document preparation. Many of our prices are listed on the table at the beginning of this paperwork or on our website under **“Payments”**. Please direct any questions about any other services you do not see listed to your counselor. At this time, ECCC does not provide general case management, medication management, and or housing; however, our counselors do have access to other community resources and/or agencies which do provide those services.

**Telehealth Consent**:  
 During the course of your services with Empowering Choices Counseling, you and your counselor may use telehealth / video communication for your session. The telehealth technology we use does not record the visit and is designed to protect your privacy. If the video system is not working we may attempt to complete the session by a telephone voice call. To ensure your privacy when using telehealth we highly suggest that you be aware of who may hear or see you during your session. We recommend finding a private place for the session. For your video session, use an internet network that is private and secure. There is a very small chance that someone could use technology to hear or see your video visit.  
  
 **Therapy dog consent:** During the course of your services with Empowering Choices Counseling you may encounter one of our therapy dogs. A therapy dog is intended to be an addition to the counseling experience by providing benefits such as increased engagement, emotional support, and the promotion of relaxation. While therapy dogs provide many benefits, there are risks involved. Examples include the possibility of the dog nibbling, scratching, licking, jumping, or being a source of an allergy. Our dogs are trained, which reduces these risks, but does not eliminate them entirely. The client or the counselor may end the use of the therapy dog in a session at any time. By providing my consent to services, I acknowledge these risks.

**Consent to Treatment:**

I have read the above information about which I have had the opportunity to ask questions. I understand the limits of confidentiality and the risks associated with counseling. If there are children involved in counseling, I hereby consent to their treatment and affirm I am the legal guardian with the authority to consent to their treatment. I agree to the payment and billing policies outlined above and accept full responsibility for any and all fees charged for counseling sessions, cancellations, or missed appointments. I consent to participate in counseling and understand that I may decline services at any time. I am aware that my counselor may consult periodically on client issues with other clinicians at Empowering Choices Counseling and Consultation, with clinical supervisors, or both. My signature below indicates that I have read, understand, and agree to accept the policies outlined in this document. Copies of documents are available upon request.

☐ I agree to pay the standard fee of $150-$250 as agreed upon by Empowering Choices.

☐I will be using my insurance and agree to pay the contracted co-pay**.**

☐ I need an adjusted fee based on my ability to pay. Agreed upon amount per session: \_\_\_\_\_\_\_\_\_\_\_\_\_

| Client Signature: |  | Date: |  |
| --- | --- | --- | --- |

| Counselor Signature: |  | Date: |  |
| --- | --- | --- | --- |

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**Authorization for Insurance Billing**

**Counselor:**  **Client:**

Please check with your insurance company (there are tips on our web site) prior to receiving services to answer the following questions:

☐ Deductible Amount-How much of your deductible have you met for the current year?: ☐ Co-Pay Amount:

☐ Does your insurance require pre-authorization?:

☐ Anniversary date of Coverage:

☐ Copy of insurance card has been provided:

***A copy of the insurance card will be required at the time of initial visit***

**(Fill out the following ONLY if copy of card was NOT provided)**

**Primary Insurance: ID#: Group#:**

**Subscriber (Name on policy): DOB:**

**Employer:**

**Secondary Insurance: ID#: Group#:**

**Subscriber (Name on policy): DOB:**

**Employer:**

I authorize that the above information is accurate and true to the best of my knowledge. I authorize my insurance company to pay Empowering Choices Counseling & Consultation directly for services rendered according to my mental health coverage. I authorize Empowering Choices Counseling & Consultation to provide all information my insurance company(ies) request(s) concerning my treatment. I understand that I am responsible for pre-authorization or doctor’s referral if required. I understand that I am financially responsible for services performed, whether or not, paid by insurance. I understand that any money received in excess of my charges will be refunded when my bill is paid in full. I understand I am responsible for a $40 cancellation fee per session canceled without a 24-hour notice.

Signature of client or responsible party:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

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**Child Intake Questionnaire**

**In order for us to provide the most complete care to you as our clients, please complete this form. If you are not sure about any of the questions, or feel uncomfortable answering them, please feel you can leave them blank. Feel free to speak with your counselor about any areas of concern you have.**

*Family Relationships*

**Complete parental information for all that apply:**

| **Questions** | **Biological Mother** | **Stepmother** | **Biological Father** | **Stepfather** |
| --- | --- | --- | --- | --- |
| **Current Age** (if deceased, date, age, & cause) |  |  |  |  |
| **Country of Origin** |  |  |  |  |
| **Occupation** |  |  |  |  |
| **Religious/Spiritual Affiliation** |  |  |  |  |
| **Highest Level of Education** |  |  |  |  |
| **Any History of the Following?** | **☐** Learning Problems  **☐** Speech Problems  **☐** Medical Problems  **☐** Emotional Problems  **☐** Substance Abuse or Addiction | **☐** Learning Problems  **☐** Speech Problems  **☐** Medical Problems  **☐** Emotional Problems  **☐** Substance Abuse or Addiction | **☐** Learning Problems  **☐** Speech Problems  **☐** Medical Problems  **☐** Emotional Problems  **☐** Substance Abuse or Addiction | **☐** Learning Problems  **☐** Speech Problems  **☐** Medical Problems  **☐** Emotional Problems  **☐** Substance Abuse or Addiction |
| **Describe Relationship with Child** |  |  |  |  |

**Siblings:**

Please list your child’s siblings in order of birth, including step and adopted

| **First Name** | **Biological, Step, or Adopted** | **Current Age** | **School Grade** | **Gender** | **Lives with you? (y/n)** | **Any Medical, School, or Social Problems?** |
| --- | --- | --- | --- | --- | --- | --- |
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| Parent/child Relationship |
| --- |
| **Parents are:**  **☐ Married ☐ Divorced ☐ Separated ☐ Living Together** |
| **If separated or divorced, how old was the child when the separation occurred?:** |
| **Child lives with (choose one):**  **☐ Both Parents ☐ Mother ☐ Father ☐ Other:** |
| **Who has legal custody (choose one):**  **☐ Both Parents ☐ Mother ☐ Father ☐ Other:** |
| **Please describe the current visitation schedule if any:** |
| **What do you find most challenging in parenting your child/adolescent?:** |
| **What kind of discipline works best with your child/adolescent?:** |
| **What are some of the activities you do together as a family?:** |

*History of mental health problems/diagnosis/treatment*

| ***Diagnosis*** | ***Date/Age*** | ***Who did the diagnosis?*** |
| --- | --- | --- |
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| **Does anyone in your direct or extended family have mental illness?:** |
| --- |

*General Questions*

| **What is the main reason(s) you are seeking help for your child? (Include how long he/she’s had these symptoms/problems):** |
| --- |
| **What are your hopes regarding your child’s therapy?** |
| **What are your child’s strengths?** |
| **What hobbies or activities does your child enjoy?** |

| **Education** |
| --- |
| **Is your child/adolescent currently enrolled in school? ☐ Yes ☐ No**  **Name of school:** |
| **What grade is your child currently in (if summer, what grade is your child going into)?:** |
| **How would you describe your child’s attendance (currently)?**  **☐ Attending regularly ☐ Home-schooled ☐ Some truancy**  **☐ Alternative school ☐ Expelled ☐ Dropped Out**  **☐ GED program** |
| **How would you describe your child/adolescence grades in school?:** |
| **How would you describe your child/adolescent’s attitude towards school/education?:** |
| **Disciplinary or behavioral issues at school? ☐ Yes ☐ No If yes, describe:** |
| **Please check if your child has any of the following:** |
| **☐ Special Education Accommodation or a 504? Please describe:** |
| **☐ An Individualized education Plan (IEP)? Please describe:** |
| **☐ Diagnosed Learning Disability? Please describe:** |
| **☐ Receiving Special Services at school? Please describe:** |

| **Please describe your child’s social support network (check all that apply):**  **☐ Family ☐ Neighbors ☐ Friends ☐ Students ☐ Coworkers**  **☐ Support Group ☐ Community Group**  **☐ Religious/Spiritual Center (which one?)** |
| --- |
| **To which cultural group (s) does your child/adolescent belong?:** |
| **If your child is experiencing any difficulties due to cultural or ethnic issues, please describe:** |
| **How important are spiritual matters/values to you? ☐ Not at all ☐ Little**  **☐ Somewhat ☐ Very much** |
| **Would you like spiritual/religious beliefs to be incorporated into your child’s counseling?**  **☐ Yes ☐ No** |

| **Substance Use:** |
| --- |
| **Does your child/adolescent drink?: ☐ Yes ☐ No**  **If so, how often:**  **If so, how much in one setting?:** |
| **Does your child/adolescent use substances?: ☐ Yes ☐ No**  **If so, how often:**  **Please list substances your child/adolescent has used:** |

*Developmental History*

| Prenatal and Delivery History |
| --- |
| **How was the mother’s overall health during pregnancy with this patient? ☐ Good ☐ Fair**  **☐ Poor ☐ Don’t know** |
| **How was the mother’s overall health during delivery with this patient? ☐ Good ☐ Fair ☐ Poor ☐ Don’t know** |
| **Did the mother experience any medical problems or complications during pregnancy?**  **☐ Yes ☐ No**  **If yes, please specify:**    **How old were the parents when this patient was born? Mother: Father:** |
| **What substances, if any, did the mother use during the course of the pregnancy (including before learning that she was pregnant)?** |
| **Was this child/adolescent born: ☐ less than 30 weeks gestation ☐ 30-35 weeks ☐ 36-40 weeks**  **☐ over 40 weeks**  **Was delivery: ☐ Normal ☐ Breech ☐ Caesarian ☐ Forceps/vacuum assisted ☐ Induced**  **What was the child/adolescent’s birth weight?**  **Were there indications of fetal distress during labor/birth? ☐ Yes ☐ No**  **If yes, please specify:** |
| **Toddler Period** |
| **As an infant/toddler, how did this child/adolescent behave with other people?**  **☐ More social than average ☐ Average sociability ☐ Actively avoided socializing**  **☐ More shy than average**  **As an infant/toddler, how insistent was this child/adolescent when he or she wanted something?**  **☐ Very insistent ☐ Somewhat insistent ☐ Average ☐ Passive**  **As an infant/toddler, how active was this child/adolescent?**  **☐ Very insistent ☐ Active ☐ Average ☐ Less active ☐ Very active**  **How would you describe this child’s play as an infant/toddler? (Check all that apply)**  **☐ Loud ☐ Interested in playing with others ☐ Imaginative/Make believe**  **☐ Quite ☐ Played alone ☐ Repetitive ☐ Rigid, concrete** |
| **Developmental Milestones** |
| **Have you or anyone else ever had concerns about this child/adolescent’s development?**  **☐ Yes ☐ No**  **If yes, please specify:**  **At what age (in months) did this child/adolescent:**  **Sit up: Crawl: Walk:**  **At what age (in months) did this child/adolescent speak single words (other than “Mama” or Dada”)?:**    **At what age (in months) did this child/adolescent begin stringing two or more words together?:** |

| Current prescriptions medications: ☐ None | | | |
| --- | --- | --- | --- |
| **Medication** | **Dosage** | **Date First Prescribed** | **Prescribed By** |
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*Medical Background*

| **Name of primary care physician:** |
| --- |
| **When was your child’s last complete physical exam?** |
| **What types of foods does he/she often eat?** |
| **How often does your child exercise? What type and how long?** |

| **Has your child experienced any of the following medical conditions or issues during his/her lifetime?**  **☐ Allergies ☐ Surgery ☐ Serious Accident ☐ Head Injury**  **☐ Chronic Pain ☐ Asthma ☐ Headaches ☐ Stomach Problems**  **☐ Dizziness/Fainting ☐ Meningitis ☐ Seizures ☐ Vision Problems**  **☐ High Fevers ☐ Diabetes ☐ Hearing Problems ☐ Miscarriage**  **☐ Epilepsy or Seizures ☐ Abortion ☐ Sleep Disorder**  **☐ Thyroid Disease ☐ Cancer ☐ Heart Disease ☐ Kidney Disease**  **☐ Fibromyalgia ☐ Multiple Sclerosis ☐ Fertility/Pregnancy Issues**  **☐ Other:**  **Please list any CURRENT health concerns:** |
| --- |

| 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 |  |  |  |

| Mental Health |
| --- |
| **Current Symptoms Checklist: (check which ones apply)** |
| ☐ Depressed mood ☐ Racing thoughts ☐ Excessive worry  ☐ Unable to enjoy activities ☐ Impulsivity ☐ Anxiety attacks  ☐ Sleep pattern disturbance ☐ Increased risky behavior ☐ Avoidance  ☐ Loss of interest ☐ Increased libido ☐ Hallucinations  ☐ Concentration/forgetfulness ☐ Decreased need for sleep ☐ Suspiciousness  ☐ Change in appetite ☐ Excessive energy ☐ Fatigue  ☐ Excessive guilt ☐ Increased irritability ☐  ☐ Decreased libido ☐ Crying spells ☐ |
| **Suicide Risk Assessment** |
| **Has your child ever had thoughts, made statements, or attempted to hurt him/herself?**  **☐ Yes ☐ No**  **If yes, please describe:**  **Has your child ever had thoughts, made statements, or attempted to hurt someone else?**  **☐ Yes ☐ No**  **If yes, please describe:**  **Has your child ever restricted their eating or eaten in a way that made you uncomfortable?**  **☐ Yes ☐ No**  **If yes, please describe:**  **Has your child recently been physically hurt or threatened by someone else?**  **☐ Yes ☐ No**  **If yes, please describe:** |

| **Psychiatric/Psychological History** |
| --- |
| **Is your child currently being seen by a counselor? ☐ Yes ☐ No**  **If yes, name of current counselor: Length of Treatment:** |
| **Is your child currently being seen by a psychiatrist? ☐ Yes ☐ No**  **If yes, name of current psychiatrist: Length of Treatment:** |
| **Has your child ever been diagnosed with a mental health, emotional, or psychological condition?**  **☐ Yes ☐ No**  **If yes, what diagnosis was your child given?:**    **When?: By whom?:** |