**INFORMATION FOR CLIENTS**

Welcome to my practice. I appreciate you giving me the opportunity to be of help to you. This document contains information about my professional services and business policies. Please read it and jot down any questions that you might have so that we can discuss them.

About therapy:

Most people attend behavioral health treatment because they are seeking change or growth in some area of their life. The effectiveness and perceived benefits of treatment depend on many factors including the particular problems you are experiencing, personality factors, establishing a good therapeutic alliance, and your ability and willingness to actively participate in your treatment.

While the prospects for change are exciting, giving up old habits or beliefs, no matter how destructive or painful, is difficult and can make people feel vulnerable and anxious. Some people will experience uncomfortable emotions throughout treatment. Exploring unpleasant aspects of one’s past can cause initial discomfort, but is often essential in working through and resolving experiences that impede the ability to reach your optimal level of functioning.

One of the benefits of therapy is having an objective, non-judgmental ally to assist you through these potentially uncomfortable emotions or memories. Together we will identify patterns or behaviors that are unhelpful and develop alternative ways of coping. While the benefits of treatment vary, clients often report gaining a better understanding of themselves and their goals and values, being able to access and tolerate a wider range of emotions, improvement in interpersonal relationships, development of problem solving and coping skills, enhanced self-esteem and an increased confidence in their ability to manage problems and stress.

While there is no guarantee that treatment will create the desired changes or effects, most people find that the benefits of therapy outweigh any risks. In fact, sometimes there can be more risk associated with not participating in treatment and maintaining maladaptive behaviors and thought patterns.

By the end of our initial session, I will be able to offer you some initial impressions of what our work will include if you decide to continue. Together we will clarify treatment objectives and develop a plan to meet your goals. Throughout the treatment process we will periodically review your progress and make any necessary adjustments to best meet your needs.

Termination and premature discontinuation of services:

Typically therapy will end once treatment goals and objectives have been met; however, you have the right to terminate therapy at any time for any reason. If you decide to discontinue services I ask that, rather than just not returning, you schedule a final appointment so that we can review your progress and discuss any referrals that might be beneficial to you. You are, however, under no obligation to return if you are uncomfortable doing so.

I have the right to discontinue treatment if:

* Cancellations and no shows become an issue and are unable to be dealt with in the therapeutic relationship, as described above
* If I am not, in my judgment, able to help meet your needs either because they are beyond my scope of practice or because the severity of symptoms are not able to be safely managed at this level of care.
* If you act violently (verbally or physically), threaten or harass me I will discontinue therapy immediately

If I terminate treatment I will provide you with referrals to alternative providers to meet your needs. If you are interested in resuming services with me and feel that the circumstances leading to my decision to discontinue services has changed, please contact me to discuss this.

If at any time during the course of treatment you feel I have violated your rights or feel I have acted in an unethical manner you have the right to file a grievance against me.

If I have reason to believe that you are under the influence of drugs or alcohol at the time of our session, I may end the session and require you to find a safe method of transportation to your residence. If a client is required to take a cab home they will be responsible for the full cost of transportation.

After hours on call:

My practice is conducted on an outpatient basis, and designed to accommodate clients that are reasonably safe. Therefore, I cannot guarantee that I will be immediately available 24 hours a day 7 days a week. If either you or I feel that this level of support is not adequate, we can discuss additional resources and/or a transfer to a higher level of care or a provider with 24 hour coverage. That being said, every effort will be made to respond to all calls promptly.

If you feel your matter is an emergency and you cannot reach me please call 911 or go to the nearest emergency room.

Financial policy:

My fee is $175 for an initial diagnostic assessment (typically lasting one to one and a half hours) and $125 per session for subsequent treatment visits (typically lasting 45-50 minutes). **Currently, I am credentialed with: Husky/Medicaid, Anthem Blue Cross and Blue Shield and Cigna.**

There are both positives and negatives to using insurance for counseling. Some clients will decide, regardless of coverage available to them, to pay for services out of pocket. If you would like to discuss the pros and cons of using managed care benefits, please let me know.

Please note, if you do decide to utilize your insurance to pay for services, ultimately the cost of services rendered is your (and not the insurance company’s) responsibility. Therapy fees may constitute a tax deductible medical expense and you may request a receipt for such purposes.

As a licensed clinical social worker, my professional services qualify for reimbursement under most plans accepting out of network providers.

If you decide that you would like to use the mental health benefits available through your insurance company, with who I am not currently in network, you will be responsible for paying in full at the time of service and I will provide you with the necessary documentation to be reimbursed through your insurance company.

You may want to contact your insurance company to ask the following questions:

* Do you accept out of network providers?
* What is the reimbursement rate (or percentage) for therapy sessions with an out of network providers?
* Is there a deductible?
* Does mental health treatment require pre-authorization?
* How many sessions are covered per calendar or plan year?
* What personal and treatment information is required to be submitted?
* Are there any specific forms that must be submitted for reimbursement?

A sliding scale fee is available for a limited number of clients who do not have, or do not wish to use, mental health benefits through their insurance. A fee agreement will be established in such cases.

Additional Fees:

I charge $60 an hour for other professional services you may need, however, I will break down the hourly cost (in 15 minute increments) if I work for periods of less than one hour. Examples of “other services” include:

* Report writing (for lawyers, probation, Social Security Disability…)
* Telephone consultations with other professionals at your request
* Phone conversations lasting longer than 10 minutes that are not of an emergent nature
* Appearances at a court proceeding
	+ I will only appear at court when subpoenaed to do so. If you become involved in legal proceedings that require my participation there will be a fee for case preparation and my attendance. This charge will be determined based on the complexity of the case and the amount of time required.
	+ In order to preserve and respect the positive therapeutic relationship that is built through my work with both you and your family, I will not perform evaluations or make recommendations for the purpose of custody conflicts, including visitation. I will be happy to speak about your child’s mental health and treatment, as it relates to their symptoms and functioning, or coordinate with the assessing professional regarding mental health treatment with your consent.
* If you fail to make payments for which you are responsible within 60 days, your account will be charged an additional 1.25% interest fee.
	+ If your account remains unpaid and becomes delinquent and is sent to a collection agency, you will be responsible for additional fees incurred in the collection process.

No show/ late cancellation policy:

Please allow at least 24 hours notice if you will not be able to keep a scheduled appointment. If an appointment is scheduled for a Monday, cancellations must be made by 3pm the Friday before the appointment. With sufficient notice I may be able to schedule another client in your appointment space.

Please be aware that if you do not provide at least 24 hours notice of a cancellation or you do not show for a scheduled appointment you will be charged $50, unless we both agree that you were unable to attend due to circumstances outside your control. You are solely responsible for any charges for late cancellations or failed appointments as insurance will not reimburse for this.

Regular attendance is important for optimal treatment outcomes. Frequently missed sessions or prolonged absence from treatment are often signs that a person is not ready to commit to treatment or has concerns about the current treatment they are receiving. I encourage you to discuss any barriers to treatment with me directly in hopes of reaching a resolution.

\*For clients utilizing a sliding scale fee, please note that the charge for late cancellations and failed appointments remains $50.

Confidentiality:

In general, the law protects the confidentiality of all communication between a client and a licensed clinical social worker. I may only release information about your treatment to others if you sign a written authorization form. There are instances in which my professional and legal duty overrides the right to confidentiality. These exceptions include, but are not limited to, informing appropriate authorities of suspected abuse of children and vulnerable adults, and of threat of serious bodily harm to self or others. Please see attached “notice of privacy practices” document for detailed explanation.

I sometimes consult other therapists or professionals about my clients. This helps me in giving high-quality treatment. During a consultation, I make every effort to avoid revealing the identity of my clients. The other professionals are also required to keep the information confidential. If you don’t object, I will not tell you about these consultations unless I feel that it is important to our work together. I will, however, note all consultations in your clinical record.

A note for parents or guardians:

Often family involvement is important to the success of minor’s treatment; however, at times issues are best addressed individually before involving others. Clients under 18 years of age (who are no emancipated) and their parents/guardians should be aware that the law allows parents/guardians to examine their child’s records. Because privacy in psychotherapy is often crucial to successful treatment, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child’s records if I meet with the client individually. If the parent/guardian agrees, during treatment, I will typically provide only general information about the progress of treatment, and the client’s attendance at scheduled sessions. Before giving parents information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have. Additionally, I encourage parents or guardians to schedule individual appointments with me to discuss any concerns regarding their child or treatment. Please be assured that if I feel your child is in danger or is a danger to someone else, I will notify you of my concerns as soon as possible.

Please be aware that unless an order of protection or proof of termination of parental rights is provided, both biological parents have equal access to records and rights to be involved in their child’s treatment.

Use of Technology and Telehealth Options:

In the digital age that we live in there is no form of communication that is 100% confidential. That said, I take many steps to ensure your confidentiality in regards to our communication both in and out of session. I use Google Voice and Google Email in my practice. While this offers ease of communication, it does make you somewhat vulnerable to breaches of your privacy. With this in mind, please do not send confidential clinical information via email or text messaging. If you make the decision to communicate confidential information in this way, I will assume that you are making an informed decision to do so and will view this as your agreement that you have considered the possible risks involved. These modes of communication should primarily be utilized for scheduling/changing appointments. Please do not use email to reach me in an emergency as I do not check email with the same frequency that I would see a text message or hear a phone call. Additionally, communication via social media sites is not secure, or appropriate, and for your protection I will not communicate with you in this way.

Video therapy sessions may be available to you, but the appropriateness of this form of communication will be assessed on a case by case basis based on my assessment of your symptoms and functioning. A HIPAA compliant program, Doxy.me, will be utilized for these real time video sessions. Currently, these services are covered by most Cigna and Anthem plans and Husky, however, it will be your responsibility to contact your insurance company to determine if this form of treatment is covered by your specific plan and you will be held responsible for the full fee for the session in the event that it is not.

Please sign and review the additional telehealth consent form if you would like to be able to utilize these services in the future so that it remains on file. It can be revoked at anytime and the decision to utilize these services must be agreed upon by clinician prior to time of appointment.**Signature Page**

Consent for treatment:

I, the undersigned, do hereby agree and give my consent to Julia Israelski, LCSW, LLC to provide psychological/psychiatric assessment and treatment to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as considered necessary and proper in diagnosing or treating his/her condition.

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Benefit assignment/ release of information:

I authorize the use or disclosure of all information necessary, including patient records, to process insurance claims and secure payment. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations. Additionally, I authorize payment of medical benefits to Julia Israelski, LCSW, LLC for services performed.

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Financial Policy:

I have read and understand the above information. I understand my responsibility for payment of my account (including fee for services, failed or late cancellations, additional services rendered by provider on my behalf, and late fees). I understand that payment is due at the time services are rendered (co-pays, co-insurance, deductibles, or self-pay balances.

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Privacy Practices:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. acknowledge that Julia Israelski, LCSW, LLC’s “Notice of Privacy Practices” has been made available to me. I am aware that I may obtain a copy of this policy at any time. My signature below attests to an understanding of the information that has been provided to me.

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT FOR TELEMENTAL HEALTH SERVICES**

This form is to be used in conjunction with but does not replace the signed Service Agreement and Consent for Treatment that that is required for all clients receiving services from Julia L. Israelski, LCSW LLC

WHAT IS TELEMENTAL HEALTHCARE?

Telemental health is a subset of telehealth services that uses online, interactive videoconference software to provide mental health services from a distance. Telemental health includes terms such as telepsychology, telebehavioral health, online counseling, and distance counseling. Private insurance companies in Connecticut and many other states are required by law to cover telemental health services. Telehealth does not include the use of fax, audio-only telephone, e-mail, or videotelephony products such as FaceTime and Skype.

SOME POTENTIAL RISKS OF TELEMENTAL HEALTH

* Technological failures such as unclear video, loss of sound, poor internet connection, or loss of internet connection
* Nonverbal cues might be more difficult to observe and interpret during therapist and client interactions
* Must electronically share and sign practice and consent forms and accept risks that come with transmitting information and documents over the internet

BENEFITS OF TELEMENTAL HEALTH

* Less limited by geographical location and transportation concerns
* Decrease in travel time and ability to meet virtually during inclement weather conditions or illness
* Ability to participate in treatment from your own home or other environment where you feel safe, secure, and comfortable

ELIGIBILITY

Julia Israelski, LCSW LLC is only able to provide telemental health services to clients located in Connecticut, as this is the only state in which Julia Israelski holds a license to practice as an LCSW. Telemental health may not be the most effective form of treatment for certain individuals or presenting problems. If it is proven that Telemental Health services are inappropriate for any client, an appropriate recommendation will be made.

PRIVACY AND CONFIDENTIALITY

The current laws that protect privacy and confidentiality also apply to telemental health services. Exceptions to confidentiality are described in the Notice of Privacy Practices. All existing laws regarding client access to mental health information and copies of mental health records apply. Telemental health services are provided through the HIPAA compliant, secure application called Doxy.me. No permanent video or voice recordings are kept from telemental health sessions. Clients may not record or store video from sessions and if it is found out that a client has recorded any portion of a session, services with be terminated.

CLIENT EXPECTATIONS DURING TELEMENTAL HEALTH SESSIONS

* Mac/PC/Chromebook, smart phone, or tablet with camera, microphone, and speakers
* Internet connection with at least 750kb/s download and upload speeds
* Access to the Doxy.me website/application
* Proper lighting and seating to ensure a clear image of each party’s face
* Dress and environment appropriate to an in-office visit
* Engage in sessions in a private location where you cannot be heard by others
* Only agreed upon participants will be present; the presence of individuals unapproved by both parties will be cause for termination of the session
* Client must disclose the physical address of their location at the start of the session; unknown locations will be cause for termination of the session
* Client shall provide a phone number where they can be reached in the event of service disruption

EMERGENCY PROTOCOL

Client is to provide the name and contact information for a local emergency contact. If you have already designated someone as an emergency contact this person will be utilized unless otherwise specified by client. In the case of a mental health emergency during a telemental health session where a client is at imminent risk of harming themselves or someone else, Julia Israelski, LCSW will contact the client’s local emergency services. The contact information for the client’s nearest emergency room will also be on record. Release of Information forms will be completed for necessary entities unless confidentiality must be breached to protect the safety of the client or another identified individual.

PAYMENT PROCEDURES

Client must pay for telemental health services using a credit card. If a client prefers to utilize a check for payment, a credit card must be kept on file for any outstanding balances that are not paid in a timely manner, outlined in the practice policies. It is up to the client to notify Julia Israelski, LCSW before the end of the session if they wish to use a different credit card for payment or change their credit card on file.

CONSENT FOR TELEMENTAL HEALTH TREATMENT

I hereby consent to engage in telemental health services with Julia Israelski, LCSW. I understand that telemental health includes mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. I understand that telemedicine also involves the communication of my medical and mental health information. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

Guardian Signature Printed Name of Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client Printed Name of Client

Date

###### Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW THIS NOTICE CAREFULLY.**

**Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (“PHI”). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act (“HIPAA”), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.**

**I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.**

**HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

**For Treatment**.Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

**For Payment.** I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

**For Health Care Operations.** I may use or disclose, as needed, your PHI in order to support my business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

**Required by Law.** Under the law, I must disclose your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

**Without Authorization.** Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is my practice to adhere to more stringent privacy requirements for disclosures without an authorization.The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

**Child Abuse or Neglect.** I may disclose your PHI to a state or local agency that is authorized by

 law to receive reports of child abuse or neglect.

**Judicial and Administrative Proceedings.** I may disclose your PHI pursuant to a subpoena

 (with your written consent), court order, administrative order or similar process.

**Deceased Patients.** I may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person’s estate or the person identified as next-of- kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

**Medical Emergencies.** I may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. I will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

**Family Involvement in Care.** I may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

**Health Oversight.** If required,I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

**Law Enforcement.** I may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

**Specialized Government Functions.** I may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

**Public Health.** If required, I may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

**Public Safety.** I may disclose your PHI ifnecessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

**Research.**  PHI may only be disclosed after a special approval process or with your authorization.

**Fundraising.** I may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

**Verbal Permission.** I may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

**With Authorization**. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

**YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing.

**Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a “designated record set”. A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. I may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

* **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask us to amend the information although I am not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with me. We may prepare a rebuttal to your statement and will provide you with a copy. Please let me know if you have any questions.
* **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
* **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.
* **Right to Request Confidential Communication.** You have the right to request that I communicate with you about health matters in a certain way or at a certain location. I will accommodate reasonable requests. I may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. I will not ask you for an explanation of why you are making the request.
* **Breach Notification.** If there is a breach of unsecured PHI concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
* **Right to a Copy of this Notice.** You have the right to a copy of this notice.

##### COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with myself or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

**The effective date of this Notice is September 2013.**

**Child and Adolescent Intake Questionnaire**

**Patient Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it okay to leave voicemail regarding scheduling? Yes (please circle: cell # only/ all provided #s) No

Would you like to receive text messages regarding scheduling? Yes No

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

Would you like to receive e-mails regarding scheduling? Yes No

Would you like to receive e-mail reminders for your appointments: Yes No

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Highest Level of School Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current School Activities/Clubs/Sports: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Additional Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Work Home

Is it okay to leave voicemail regarding scheduling? Yes (please circle: cell # only/ all provided #s) No

Is it okay to text you regarding scheduling? Yes No Is it okay to e-mail you regarding scheduling? Yes No

Would you like to receive reminder e-mails for appointments? Yes No

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Additional Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Work Home

Is it okay to leave voicemail regarding scheduling? Yes (please circle: cell # only/ all provided #s) No

Is it okay to text you regarding scheduling? Yes No Is it okay to e-mail you regarding scheduling? Yes No

Would you like to receive reminder e-mails for appointments? Yes No

Please list the names and phone numbers of any additional parents and/our caretakers of your child:

Please provide the name and number of at least one adult that can be reached in the case of an emergency (risk to self or others or physical injury or illness). Every effort will be made to contact parent or guardian first but in event they cannot be reached the following person will be contacted.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below I consent for Julia Israelski, LCSW to contact the above person in an emergency.

Signature of Parent/Guardian: ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below I consent for Julia Israelski, LCSW to contact the above person in an emergency.

Signature of Parent/Guardian: ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral Information:**

What is (are) your main reason(s) for this visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did anyone recommend or refer you to services: Yes (I was referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) No

If no, where did you find information regarding Julia Israelski’s therapy services:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been involved in treatment with another provider in the past: Yes No

If yes, with whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly describe reason for past treatment and reasons for termination:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information:**

Insurance carrier: Anthem BC/BS Cigna Medicaid Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder’s name (if different from patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy holder’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder’s employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy holder’s Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Developmental and Family History:**

Who currently lives in the home with your child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are there any recent changes in family dynamics or relationships that may be impacting child's functioning: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List any significant concerns/experiences related to child's development (prenatal, developmental milestones, trauma): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list some of your child’s strengths: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medical Information:**

Who is your child’s primary care doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child currently under treatment with any other medical providers? Yes No

If Yes, please list other doctors and the current issues that they are providing treatment for:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like for me to speak with any above doctor regarding your child’s mental health treatment?

 Yes No

If Yes, Please sign here authorizing Julia Israelski, LCSW’s ability to obtain from and release to information from your child’s doctor.

Name of Doctor: Signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is your child currently on any medication: Yes No

If yes, please list your child’s medications and the current prescriber:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any history of physical illness or operations:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has your child gained/lost over ten pounds in the past year? Yes (please circle: gained/lost) No

If yes, was this weight change intentional? Yes No

Does your child have a history of: Binging Purging Restricting

Any other issues regarding weight and/or appetite/eating habits:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child having any issues with their sleeping patterns:

 Trouble falling asleep Trouble staying asleep Nightmares Oversleeping/sleeping too much

Does your child have a history of substance use issues: Yes No

If Yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there a history of mental health and/or substance abuse in your child’s family: Yes No

If Yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Any additional information you would like me to be aware of: ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Child Checklist of Concerns**

Please mark all of the items below that apply to your child, and feel free to add any others at the bottom under “Any other concerns or issues.” You may add a note or details in the space next to the concerns checked. Please circle the items that are of greatest concern

❑ Abuse—physical, sexual, emotional, neglect

❑ Aggression, violence

❑ Anger, hostility, arguing, irritability, talking back

❑ Anxiety, nervousness

❑ Attention, concentration, distractibility

❑ Bullies/intimidates, teases, inflicts pain, bossy

❑ Compulsions

❑ Complains/whines

❑ Conflicts with parents

❑ Cries easily, feelings are easily hurt

❑ Cruelty towards animals

❑ Dawdles, procrastinates, wastes time

❑ Decision making, indecision, mixed feelings, putting off decisions

❑ Delusions (false ideas)

❑ Dependent, immature

❑ Depression, low mood, sadness, crying

❑ Developmental Delays: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Difficulties with changes in family dynamics

❑ Disobedient, uncooperative, noncompliant

❑ Distractible, inattentive, poor concentration

❑ Drug or alcohol abuse

❑ Eating problems: over eating, under eating, purging

❑ Excessive Exercise

❑ Failure in school, dropped/dropping out of school

❑ Fatigue, tiredness, low energy

❑ Fears, phobias

❑ Fighting, violent, aggressive, hostile, destructive

❑ Fire setting

❑ Friendships

❑ Grieving, mourning, deaths, losses, divorce

❑ Guilt

❑ Headaches, other kinds of pains

❑ Health, illness, medical concerns, physical problems

❑ Hypochondriac, always complains of feeling sick

❑ Inferiority feelings

❑ Interpersonal conflicts

❑ Immature, has only younger friends

❑ Impulsiveness, loss of control, outbursts

❑ Irresponsibility

❑ Lacks organization, unprepared

❑ Lacks respect for authority, provokes, manipulates

❑ Learning disability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Legal difficulties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Likes to be alone, withdraws, isolates

❑ Low frustration tolerance, irritability

❑ Lying

❑ Memory problems

❑ Menstrual problems, PMS, menopause

❑ Mental Retardation

❑ Mood swings

❑ Moody

❑ Motivation, laziness

❑ Mute, refuses to speak

❑ Nervousness, tension

❑ Nightmares

❑ Obedient, difficulty making own decisions

❑ Obesity

❑ Obsessive/Compulsive behavior

❑ Oppositional, refuses, does not comply with rules

❑ Overactive, restless, hyperactive, fidgety

❑ Oversensitivity to rejection

❑ Pain, chronic

❑ Panic or anxiety attacks

❑ Perfectionism

❑ Pessimism

❑ Poor relationships with siblings or friends

❑ Prejudiced, bigoted, insulting, intolerant

❑ Procrastination, work inhibitions, laziness

❑ Recent move, new school, loss of friends

❑ Rocking or other repetitive movements

❑ Runs away, threatens to run away

❑ Sad, unhappy

❑ School problems

❑ Self-centeredness

❑ Self-esteem

❑ Self-neglect, poor self-care

❑ Self-harm behaviors: picking, head banging, cutting

❑ Sexual preoccupation, sexualized acting out

❑ Shyness, oversensitivity to criticism

❑ Sleep problems: too much, too little, insomnia, nightmares

❑ Speech difficulties

❑ Spiritual, religious, moral, ethical issues

❑ Stress management, tension

❑ Suspiciousness, distrust

❑ Suicidal thoughts, talk, gestures, attempts

❑ Teased, picked on, victimized, bullied

❑ Temper tantrums, rages, low frustration tolerance

❑ Tics- involuntary rapid movements, noises, or words

❑ Threats, violence

❑ Truant, school avoidant

❑ Weight and diet issues avoidant

❑ Withdrawal, isolating

❑ Work problems, can’t keep a job, dissatisfaction, ambition

❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_