Centers for Hope & Wellness, Inc.

Patient Information

Name: ______________________________________ Date of Birth:______________________

Address :______________________________________ Social Security #:____________________

Street

_________________________________ Marital status :_______________________

City

_______ _____________ Gender: Male______ Female______

State Zip

Home Phone:_______________________ Alternate phone:_____________________

Preferred Contact Number:____________________ May we leave a message at this number: Yes___ No___

Do you want to be reminded via email of appointments? Yes ____ No ____

Email Address: _______________________________________

Emergency Contact Name: _______________________________ Relationship to Patient: _____________

Emergency Contact Number: _______________________

Primary Care Physician: ____________________________ Physician's Phone Number: _________________

Patient employment

( ) Employed ( ) Retired ( ) Unemployed ( ) Student ( ) Other

Employer:______________________________ Phone: ___________________ May we contact you at work: Yes No

Permission for Treatment, Guarantor's Statement, and Authorization to Release Information :
Permission is hereby granted to clinicians at the Centers for Hope and Wellness, Inc., to administer examinations, treatments, and procedures as are deemed necessary for myself and/or the patient named on this registration. I have received notification of the rights of the confidentiality of alcohol and drug abuse patient records. I acknowledge I have received notice of privacy practices. I hereby request and authorize Centers for Hope and Wellness, Inc., to release all or any part of my medical records to any insurance company(s) which is or may be liable for all or part of my charges. My signature below acknowledges that I have had an opportunity to read the Practice Agreement and understand the information contained within it; I hereby agree to abide by its content.
Assignment of insurance benefits: I hereby authorize and assign all payments made directly to Centers for Hope & Wellness, Inc., for all insurance benefits otherwise payable to me. I agree to pay all accumulated charges not covered by verified and assigned insurance. I acknowledge I have received a copy of the Privacy Policy of this office.

_______________ ________________________________ ____________________

Date Signature Relationship to Patient

RIGHTS AND RESPONSIBILITIES

Our experience has shown that when the contract terms of the counseling relationship or evaluation process are clear and explicit from the beginning, some common misunderstandings are avoided. Please read carefully and sign at the bottom.

1. You are an integral part of your evaluation and counseling; you have the right to ask questions at any point. You may refuse to participate in any evaluation task; however, an accurate evaluation is better achieved with your cooperation.
2. Questions concerning your therapist's qualifications and experience will always be answered. As well, you may refuse to participate in any intervention, strategy, or behavior suggested by your counselor.
3. Because we are a teaching practice, we may utilize interns from various graduate programs around the state. You may request or refuse services from an intern practicing at our site
4. Counseling is an interactive reciprocal experience. The counselor will always attempt to meet you, the client, where you are psychologically. Your cooperation in the relationship is central to its' success.
5. A referral will be provided based on your need or at your request.

CONFIDENTIALITY:

6. Within certain legal and ethical limits, information revealed by you will be kept strictly confidential and will not be disclosed to another person or agency without your written permission. The limits to this policy are as follows:

- If a court of law issues a subpoena, we are required to provide the information required by subpoena.
- If a court of law has ordered you to participate in counseling or to be evaluated by our staff, the results of the treatment or assessment must be revealed to the court.
- If you threaten physical injury or death to yourself or another person, we must take steps necessary to protect you or other involved individuals. (This includes disclosure to appropriate authorities or relevant individuals).
- If you or your child discloses emotional/physical/sexual abuse of a minor, we are required by law to report this to the local children's protection agency.
- If you were sent here to be evaluated by an attorney, insurance agency, Social Security, or your employer, we must comply with disclosure.

7. You have the right to be informed about policies regarding fees and services.
   - Payment is due at time of service.
   - Co-payment or deductible will be due after each session, unless we have a contract with your carrier stating no payment is due.
   - Fees are based on the type/length of services you receive. You'll also be responsible for charges incurred on your behalf with other professionals/agencies, court appearances, test scoring, interpretation or preparation.
   - Clients presenting for intensive treatment are contracted to pay at the beginning of their program. Contracted clients may terminate treatment at any time at their discretion.
   - We reserve the right to terminate treatment for non-payment of fees and services provided.
   - Unpaid accounts greater than one session will result in suspension of services until payment is received.
8. You have the right to terminate services at any time.
9. If you cancel or do not show for a scheduled appointment and we do not hear from you for 30 days, then it will be assumed that you are no longer under our care.
10. There will be an additional charge for processing forms other than medical insurance (i.e. disability).
11. It is your responsibility to become familiar with your own mental health benefits if you are using insurance, prior to entering into a treatment contract with your counselor. Our staff may be able to provide you with some insurance information but due to the various plans with each carrier and their confidentiality policies, we cannot guarantee the accuracy of information we receive from your carrier.

APPOINTMENTS

Your appointment time is set aside just for you. We look forward to meeting you at your reserved time. If you miss an appointment without notice, this means that another person is not able to use that appointment time.

Unless there are circumstances your counselor and you would define as an illness or emergency, it is our policy to charge a fee when an appointment is not canceled 24 hours in advance, or is missed. **If an appointment is canceled less than 24 hours in advance or is missed, you will be charged $120. Clients who are being assisted by a local church will be charged $60 for a missed or late-canceled appointment. You are allowed 1 missed/late-canceled appointment without charge.**

Our office reserves the right to enforce one or more of the following options:

- You will be charged for the missed appointment (please note that this service charge will not be covered by your insurance).
- Your full session fee will be billed at time of service, and payment is due at that time.
- Termination from our practice will occur if multiple appointments are missed.

I have read and understand my rights and responsibilities.

____ ________________________
Signature of Client Date

____ ________________________
Signature of Client Date

CHILD AND ADOLESCENT BEHAVIOR QUESTIONNAIRE

Name of child/adolescent:_______________________________________ Date: ________________

Name of person answering:__________________________________ Relationship: _____________

INSTRUCTIONS: Please read each item carefully, If an item applies to this person in the last month, circle its number.

BEHAVIOR

1. Does things without thinking
2. Violates curfew and other house rules
3. Destroys property or belongings
4. Steals
5. Lies often
6. Has been in trouble with the police or on probation
7. Has sexual problems
8. Has run away from home
9. Has attempted to talk about suicide
10. Argues when told to do something
11. Delays doing as asked
12. Is cruel to animals
13. Has to have everything his/her own way
14. Often tries to be the center of attention
15. Has temper tantrums
16. Acts like a younger child
17. Curses
18. Sets fires
19. Has nervous habits
20. Often pouts and sulks
21. Prefers to be alone/avoids activities
22. Plays with weapons, knifes, guns, etc

FEELINGS

1. Is upset by any changes in routines or schedules
2. Has a lot of fears
3. Lacks self-confidence
4. Feels sad a lot / cries easily
5. Does not seem to feel guilt
6. Is extremely critical
7. Seems afraid to make mistakes/easily embarrassed
8. Resents even gentle criticism
9. Does not like to be touched
10. Has an "I don't care" attitude
11. Has a " you can't make me" attitude
12. Feels angry a lot
13. Feels bored a lot
14. Is afraid of "rough play"
15. Has frequent nightmares

PHYSICAL

1. Has a lot of physical complaints
2. Has trouble falling asleep
3. Is seriously overweight or underweight
4. Has lost or gained a lot of weight recently
5. Sleeps a lot
6. Has hearing problems
7. Has speech problems
8. Has poor bladder control during the day
9. Has poor bowel control during the day
10. Wets the bed at night
11. Has vision problems
12. Is clumsy and awkward
13. Is tired much of the time

ACADEMIC

1. Is truant from school
2. Grades have dropped
3. Doesn't complete assignments in the classroom
4. Doesn't do homework
5. Has a learning disability and/or mental retardation
6. Feels unfairly treated by teachers and/or admin.
7. Has short attention span
8. Often clowns in class
9. Refuses to go to school
10. Is poorly coordinated in seat work
11. Can't sit still
12. Makes below average grades
13. Rarely speaks up in class
14. Has difficulty working in groups
15. Rarely works without individual attention
16. Been suspended from school

FAMILY

1. Gets along poorly with brothers/sisters
2. Avoids contact with family members
3. Gets along poorly with mother/stepmother
4. Gets along poorly with father/stepfather
5. Parents get along poorly with each other
6. Clings to parents

SOCIAL/PEERS

1. Hangs around with bad crowd
2. Is too easily led by others
3. Chooses friends a lot younger
4. Chooses friends a lot older
5. Is often teased by others
6. Doesn't like being alone
7. Has few friends
8. Tattles on other children
9. Teases other children
10. Seems shy
11. Often boasts
12. Often interrupts others
13. Won't argue or fight back when most would
14. Fights
15. Has ever been sexually molested
16. Uses alcohol
17. Uses drugs
18. Sells drugs
19. Smokes cigarettes

THINKING

1. Seems preoccupied with certain thoughts
2. Daydreams more than most
3. Says or does things over and over
4. Hears or sees things that aren't there
5. Seems unaware at time of what is happening around them
6. Has trouble concentrating
7. Has ideas that don't make sense

Centers for Hope & Wellness, Inc.

YOUTH PERSONAL HISTORY FORM

CLIENT NAME: ____DATE:________________________________

CLIENT AGE: ______________________ DATE OF BIRTH: ____

PERSON FILLING OUT FORM: ____

GUARDIAN: ____ TELEPHONE: ____________________________

PARENTS NAMES: __________________________________ TELEPHONE: ____________________________

FAMILY STATUS

1) Status of biological parents ☐ Married ☐ Separated-when________ ☐ Divorced- When________

☐ Never Married ☐ Deceased- when ________ ☐ Partnered

2) Child Lives with: ____ How long? ___________________________________

3) Custody arrangement or visitation information: ☐ None or describe: ____

4) At any time in the past has the youth been placed outside the home? ☐ Yes ☐ No

If yes, please explain____

CURRENT HOUSEHOLD

NAME	AGE	RELATIONSHIP TO YOUTH	HOW DOES THE YOUTH GET ALONG WITH THIS PERSON?

SIGNIFICANT OTHERS OUTSIDE THE HOME (e.g., Non-Custodial parent, step parents, adult siblings, grandparents)

NAME	AGE	RELATIONSHIP TO YOUTH	HOW DOES THE YOUTH GET ALONG WITH THIS PERSON

7517 Beechwood Centre, Suite 300 Avon, IN 46123

317-272-8138 Phone 317-272-8165 Fax

Are there any family members or relatives who have suffered from alcohol problems, drug problems, mood disorders, depression, anxiety, or thought disorders? Please explain and give details.

____
____
____
____

Youth and Parent Educational History

Current Grade ____ Average Grades _____ Grades Repeated ______ Can patient read/write Y N

Favorite Class: ________________ Least Favorite Class: __________

Class in which child performs best: _______________ Class in which child performs worst __________

Child learns best by: Reading __________ Demonstration __________ Doing__________ Hearing _______

School Currently Attending: ______________________ Teacher/Counselor: ______________________

Relationships with Teachers/Counselors: Excellent ___ Good ___ Average ____ Poor ____

Extracurricular Activities: ____

Ever Suspended or Expelled Yes ____ No ____ If yes, when and reason _______________________

Truancy: Yes ____ No ____ If yes, describe ______________________________

Learning Disabilities: Yes ____ No ____ If yes, describe ______________________________

Does school provide any accommodations Yes ____ No ____ If yes, describe ______________________________

Any previous testing Yes ____ No ____ If yes, when and reason _______________________

Educational Level of Mother _______________________Educational Level of Father___________________
Family History of Learning Disabilities Yes ____ No ____ If yes, describe _________________________

Developmental History
Problems with Pregnancy/Birth Yes ____ No ____ If yes, describe ______________________________
Problems with Infancy to 2 years Yes ____ No ____ If yes, describe ______________________________
Problems with 2 to 5 years Yes ____ No ____ If yes, describe ______________________________
Problems with 5 to 12 years Yes ____ No ____ If yes, describe ______________________________
Problems in Middle School Yes ____ No ____ If yes, describe ______________________________
Problems in High School Yes ____ No ____ If yes, describe ______________________________

Work History
Has youth ever been employed Yes ____ No ____ If yes, where _______________________________

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YOUTH PERSONAL HISTORY FORM

Self-Care

Has the youth had day/night wetting or soiling Yes ____ No ____ If yes, describe ____________________

Age at first sitting up ____ Age at first rolling over ____ Age of crawling ____ Age of walking ____

Age at first word _____ Age at first several word phrase ____Age of toilet training ______ Any regressions _____

Does youth have any bedtime rituals or fears: Yes ____ No ____ If yes, describe ___________________________

Does youth bathe regularly: Yes ____ No ____ Any difficulties with hygiene_________________________

Does the youth brush his or her teeth: Yes ____ No ____ Any difficulties _______________________________

Any difficulties with eating or with meals: Yes ____ No ____ If yes, describe ___________________________

Aggressive Behaviors or Threats

Verbal: Yes ____ No ____ If yes, describe ____

Physical Yes ____ No ____ If yes, describe ____

Property Destruction Yes ____ No ____ If yes, describe ____

Fire Setting: Yes ____ No ____ If yes, describe ____

Cruelty to Animals Yes ____ No ____ If yes, describe ____

Discipline Practices

Yelling ____ Time Out ____ Grounding ____ Spanking ____ Loss of Privileges ____ Rewards ____

Outcomes of discipline practices: ____

Who is the primary disciplinarian in the home ____

Is disciplined followed through with consistency ____

Substance Use (drugs,alcohol)

Have you had reason to be concerned about or discovered use of tobacco, alcohol, or drugs by your child/teen?

Yes ____ No ____ If yes, describe ____

Spiritual

Does the youth have a supportive religious or spiritual community Yes ____ No ____

Religious/spiritual community is:

Extremely important to caretaker ____ important to caretaker ____ not important to caretaker____

Extremely important to youth ____ important to youth ____ not important to youth ____

Current Medications

Medication	Dose	Purpose	Prescriber
______________	_______	_____________	______________
______________	_______	_____________	______________
______________	_______	_____________	______________
______________	_______	_____________	______________
_______________	_______	_____________	______________
_______________	_______	_____________	______________
_______________	_______	_____________	______________

Leisure Activities

Please describe how your family spends time together: ____

____

How does the youth spend time with friends: ____

____

How does the youth spend time alone: ____

____

Does the youth share a bedroom with someone else Yes ____ No ____ If yes, describe how they get along

____

Legal

Any history of arrests or legal charges: Yes ____ No ____ If yes, describe _____________________________

Any current pending charges: Yes ____ No ____ If yes, describe ____

Probation Officer Yes ____ No ____

If yes, name and contact information for Probation Officer ____________________________________

Does youth parent/guardian approve of his or her peers? Yes ____ No ____

If no, describe concerns _______________________ ____

Is there suspected gang activity Yes ____ No ____ If yes, describe ___________________________________

Has the youth ever ran away from home Yes ____ No ____ If yes, describe _____________________________

Sexual Activity

Is the youth sexually active or had sexual relations Yes ____ No ____

Any concern of pregnancy Yes ____ No ____

Any previous pregnancies Yes ____ No ____ If yes, what was the outcome of the pregnancy ________________

Abuse

Any concerns youth has been the victim of the following

Physical abuse ______ Emotional Abuse _____ Sexual Abuse _____ Bullying _____ Witnessed Violence _____