Island Behavioral Medicine

PATIENT REGISTRATION

PATIENT INFORMATION	**Last Name**	**First Name**	**Middle Initial**
Mailing Address	**City**	**State**	**Zip**
Home Telephone	**Race**	**Religion**	**E-mail address:**

Daytime Phone ☐ work ☐ cell ☐ other	**Marital Status**	**Birth Date**	**Social Security No.**	**Sex**
Mother's Name (if patient is minor)	**Father's Name (if patient is minor)**		**Primary Care Physician**	

SUBSCRIBER	**Last Name**	**First Name**	**Middle Initial**
Address	**City**	**State**	**Zip**

Home Telephone	**Relationship to Patient**	**Birth Date**	**Social Security No.**	**Sex**

Employer			
Employer's Address	**City**	**State**	**Zip**

Employer's Telephone **Ext.**	**Employment Status** ☐ **Full Time** ☐ **Part Time** ☐ **Retired** ☐ **Self** ☐ **None** ☐ **Unknown**

PATIENT EMPLOYMENT	**Employment Status** ☐ **Full Time** ☐ **Part Time** ☐ **Retired** ☐ **Self** ☐ **None** ☐ **Unknown**
Occupation	**Employer**

Address	**City**	**State**	**Zip**

Employee's Telephone **Ext**	**Employer's Telephone** **Ext**

PRIMARY INSURANCE	**Primary Insurance Company**
Insured Name	**Policy Effective Date**
Relationship to Subscriber	**Subscriber ID or Medicare No.**
Group No.	**Plan No.**
Subscriber's Employer	

Island Behavioral Medicine

SECONDARY INSURANCE	Secondary Insurance Company
Insured Name	Policy Effective Date
Relationship to Subscriber	Subscriber ID or Medicare No.
Group No.	Plan No.
Subscriber's Employer	

NEXT OF KIN/EMERGENCY CONTACT		Relationship to Patient	
Last Name	First Name		Middle Initial
Address	City	State	Zip
Home Telephone	Daytime Telephone	Cell Telephone	

FINANCIAL RESPONSIBILITY, RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I understand that I am financially responsible for any unpaid balance. I hereby authorize my insurance benefits to be paid directly to my provider. I authorize my provider or insurance company to release information required for processing my claims.

Signature Date

AUTHORIZATION FOR TREATMENT OF A MINOR

I authorize treatment of the above patient who is a minor and hereby state that I am the natural parent or legal guardian having custody of the named minor.

Signature Date

Island Behavioral Medicine

General Consent to Treatment

I, the undersigned patient or patient's representative, request care and treatment from Island Behavioral Medicine (the "Clinic"). I certify that the information I am giving is correct. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees or promises have been made as to the result of treatment or examination. I consent to and authorize, for the duration of my treatment, the following:

Medical/Behavioral Consent: I consent to all medical treatment, laboratory, diagnostic imaging, and other medical procedures performed or prescribed by the healthcare provider during my visits to the Clinic.

Release of Medical/Behavioral Information: I authorize the Clinic to release any information (including information in my medical record) necessary to facilitate processing of insurance claims and/or audit of payments relative to Clinic visits to any health care insurance company, Medicare, Medicaid and other third party payor or its designee. I also consent to the release of any information, as needed, to my referring and primary physician, and to other healthcare practitioners, facilities or agencies as I direct or as required by law.

This authorization may be revoked in writing at any time, except to the extent that actions have been taken in reliance on it. I will be financially responsible for charges incurred for treatment if revocation or refusal to authorize the disclosure of healthcare information results in denial of payment.

Financial Agreement: I hereby acknowledge that I have individual financial responsibility for services rendered that are not covered by insurance or any other party liable to me. The Clinic reserves the right to impose reasonable financing and late charges, as well as reasonable costs, attorneys' fees and expenses incurred in the collection of my account should it become delinquent. Financial responsibility will be reduced or waived if charity care eligibility is determined. I am entitled to a copy of this financial agreement at the time I sign it.

Assignment of Insurance Benefits: In the event I am entitled to medical benefits of any type whatsoever arising out of any insurance policy insuring me or any other party liable to me, said benefits are hereby assigned to the Clinic for application to my bill, and it is agreed that the Clinic may apply any such payment, and such payment shall discharge the insurance company of any and all obligations under the policy to the extent of such payment. I am responsible for charges not covered by this assignment. I authorize all insurance payments to be made directly to the Clinic, including any insurance or third party payor coverage. If I am eligible for Medicare, I authorize the Clinic to bill and collect from Medicare directly.

Medicare Certification: I certify that the information given by me or on my behalf in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. (This consent applies only when applicable.)

Personal Valuables: I acknowledge that the Clinic is not be liable for the loss or damage of any of my personal property, including any money, jewelry, documents or other articles of value.

Certification by Responsible Party: I certify that I have read and understand the foregoing and have received a copy of this Consent. I am the patient or am duly authorized by the patient as the patient's legal agent or representative to execute this Consent and accept its terms. If signing as the patient's legal agent or representative, all references in this Consent to "me," "my" or "I" shall be deemed to refer to the patient, where applicable.

______________________________________ ______________________________

Patient or other legally responsible person's signature Date

____

Relationship of legally responsible person to patient

Island Behavioral Medicine

DISCLOSURE STATEMENT

All Clinicians providing services at Island Behavioral Medicine are Mental Health Professionals currently licensed through the State of Washington (or interns working under the supervision of a licensed Mental Health Professional). Each clinician brings their own expertise to the clinic. We attempt to triage each patient in order to match them to the clinician best suited to meet their needs. You may request to see a particular clinician, however, if there is a waiting list you may choose to start with another clinician. The recommended source of treatment for you or your family will be developed between you and the clinician and will be mutually agreed upon.

OUR RELATIONSHIP

This is a professional relationship with mutually respectful boundaries. Our time together will be limited to the sessions you have with us. Professional ethics preclude invitations to social gatherings, gifts, or other dual relationships. However, given the small community where we do business, it is much more likely to know patients in other contexts. While we take great strides in clarifying this potentially dual relationship, we will discuss the potential pitfalls before beginning treatment. If this presents a problem, we will be more than happy to refer you to another qualified clinician. Should we meet socially or have a chance public encounter, any social initiative will be up to you and we will not reveal the nature of our relationship. You may at times feel quite close to your clinician, as this is the nature of personal therapy. You will be best served if the relationship stays strictly professional and if sessions concentrate exclusively on your concerns. Please bring up any questions or concerns you have about this policy.

CONFIDENTIALITY AND PRIVACY:

Please read the attached Notice of Privacy Practices for more information about your privacy rights. Please initial if you were offered the Notice form and declined your own copy:

We will keep confidential anything you say to us, with a few exceptions as required by law.

CANCELLATIONS

If you need to cancel or reschedule you can call our office 24 hours in advance of appointment time. Also, please remember to leave your home and work numbers with every message so that we can get back to you even if we are not in the office. Please notify our office at least 24 hours in advance of a missed appointment. Unless an emergency arises, Island Behavioral Medicine will charge a
$60.00 fee for missed appointments if notice is not received 24 hours in advance.

COMPLAINTS:

When possible, Island Behavioral Medicine attempts to offer a choice of Mental Health Professionals ("MHP") to those who seek services. If you do not wish to be treated by your current MHP, we will either refer you to another MHP (if available) or refer you elsewhere for services. If at any time, for any reason, you are dissatisfied with our services, please let your MHP know. If they are not able to resolve your concern, you may request problem resolution or grievance resolution (see Client Grievance Procedure). You may also report your complaint to Dept. of Health, Health Professions Quality Assurance Division, P. O. Box 47869, Olympia, WA 98504, or call (360) 236-4902.

WASHINGTON STATE REQUIRED DISCLOSURES

Counselors practicing counseling for a fee must be certified or licensed with the department of health for the protection of the public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor necessarily implies the effectiveness of any treatment. The purpose of the law regulating counselors is: (A) To provide protection for public health and safety; and (B) to empower the citizens of the state of Washington by providing a complaint process against those counselors who would commit acts of unprofessional conduct. You, as an individual, have the right to choose counselors who best suit your needs and purposes.

By signing below, I attest that I have read, understood, and agreed to these policies, and have received my own copy of this disclosure.

____ ____________________________________
Client's Signature Date Clinician's Signature Date

____
Client's Signature Date

Island Behavioral Medicine

Financial Policy

Thank you for choosing us as your behavioral health care provider. We are committed to providing you with the highest quality medical care. We believe it is important for our patients to have a clear understanding of our expectations regarding our billing and your responsibilities. Should you have any questions, please feel free to ask.

Contracted Insurance Companies: As a courtesy, we will bill any insurance company. If we are contracted we will accept as payment in full the insurance allowables (their payment + co-pay + deductible + co-insurance). If we are not contracted with your insurance company you will be responsible for any balances after the insurance payment up to the billed charges.

Patient Responsibilities: All patients must complete our "Patient Registration Form" BEFORE being seen by any of our healthcare providers. This must be updated at least once a year. Full payment is due at the time of service unless you have a current medical insurance card, which must be presented at each visit. We accept cash, checks, and credit cards. If your policy has an office visit co-payment, you must pay the co-payment at the time of service. Otherwise, an administrative fee may be billed.

It is **your responsibility** to check with your specific insurance company to determine whether this provider is a preferred provider **prior to your first appointment**.

We work with most insurance companies regarding authorizations or referrals. However, it is ultimately **your responsibility** to ensure proper authorizations or referrals are in place PRIOR to each visit. If authorizations or referrals are not approved you may be billed for the unauthorized services.

Repeated NSF checks, failure to make and keep acceptable payment arrangements, and failure to keep scheduled appointments could result in the discontinuation of your medical care within our clinic.

General Credit Policy: Patients without insurance or those with large deductibles and co- insurance are required to pay balances with the following guidelines:

- Insured: 10% discount for payment of account within 30 days of visit.
- Uninsured: 25% discount for payment of account within 30 days of visit
- Maximum 6 months for in house payment arrangements with a minimum of $50 per month.
- Arrangements over 6 months with a minimum of $50 per month with added fees and interest can be arranged through Island Behavioral Medicine Accounts Dept.

**Please note:. Delinquent accounts may be forwarded to a collection agency and scheduled visits will be cancelled. You will be unable to make appointments until acceptable payment arrangements have been made. Assistance funds may be available. Please inquire prior to your services.

Island Behavioral Medicine

Medicare: We are in the process of enrolling for Medicare. When we are approved, we will accept Medicare assignment, which means Medicare will pay our office directly. If we are not contracted with your supplemental insurance company we will bill them one time as a courtesy. If a payment is not received within 30 days you may be billed the balance up to Medicare's allowable amount.

Fees: Our clinic is committed to providing you with the highest quality medical care. Our charges are based on a value scale developed by the American Medical Association and supported by most insurance companies. Our providers are group practice physicians and behavioral health professionals. We are happy to provide you information regarding our normal charges.

Cancelations with less than 24 hours notice (unless an emergency arises), or not showing for an appointment will be subject to a $60.00 fee which will need to be paid prior to scheduling appointments.

Minors: For a child of divorced parents, we will bill whichever parent accompanies the child. We will not bill any other third party person regardless of financial arrangements.

I HAVE READ AND UNDERSTAND THE ISLAND BEHAVIORAL MEDICINE FINANCIAL POLICY

___________________________________ ___________________________________

Signature of Responsible Party Date

___________________________________ ___________________________________

Printed Patient Name Printed Responsible Party/Relationship

Island Behavioral Medicine

Island Behavioral Medicine
P.O. Box 219, Oak Harbor, WA 98277
Tel: 360-682-5016; Fax 360-682-5476

Child / Adolescent Intake Form

Child's Name:		Gender: ☐Male ☐ Female	Date completed:
Child's Date of Birth:	Social Security Number:	Home: Cell:	May we use this number to leave messages regarding his/her health/healthcare? ☐ Yes ☐ No
Street Address:		City, State, Zip:	
Parent/Guardian E-mail:		Primary Care Physician: Phone:	
School Name: Phone:		Teacher/ Counselor/ IEP Coordinator: Grade:	

Person answering questions:___________________________Relationship: _____________________

Who has current custody/guardianship of child: ☐ Mother ☐ Father ☐ Both parents
☐ DSHS ☐ Relative:__________________☐ Other: _____________________________________

If the Legal Guardian is someone other than the parents, please complete the following:
Name:___________________________________Relationship:______________________________

Address:_________________________________Phone: _____________________________________

Please describe any problems your child is currently experiencing.

____
____
____

How long has this been going on? ____

Why are you seeking services now? ____

____

What do you hope to gain from this evaluation and/or counseling? __________________________

____
____

____
____

If there have been difficulties in the past, what has been done to help him/her cope? Was it helpful? ____

Symptoms:

Please **check** any symptoms or experiences he/she has had in the last month or are related to your visit here:

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Difficulty getting out of bed Average hours of sleep per night _____________
- ☐ Not feeling rested in the morning

- ☐ Persistent loss of interest in previously-enjoyed activities
- ☐ Withdrawing from other people
- ☐ Impulsivity, low self-restraint
- ☐ Depressed mood
- ☐ Feeling numb
- ☐ Rapid mood changes
- ☐ Irritability
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Frequent feelings of guilt
- ☐ Avoiding people, places, activities or specific things
- ☐ Difficulty leaving the house
- ☐ Outbursts of anger

- ☐ Fear of certain objects or situations (i.e. flying, heights, bugs) Describe: ______________ ____
- ☐ Repetitive behavioral or mental acts Describe: __________________________________ ____

Feelings of:

- ☐ Worthlessness
- ☐ Hopelessness
- ☐ Sadness
- ☐ Helplessness
- ☐ Fear
- ☐ Feeling/acting like a different person

- ☐ Changes in eating/appetite
- ☐ Eating less
- ☐ Eating more
- ☐ Use of laxatives
- ☐ Voluntary vomiting
- ☐ Binge eating
- ☐ Excessive exercise to lose weight
- ☐ Weight gain:_______lbs.
- ☐ Trying to lose weight?
- ☐ Weight loss:_______lbs.

- ☐ Difficulty catching breath
- ☐ Easily startled/feeling "jumpy"
- ☐ Trouble staying on task
- ☐ Decreased energy
- ☐ Increased energy, on the go
- ☐ Dizziness
- ☐ Tremor
- ☐ Physical sensations others don't have
- ☐ Increased muscle tension
- ☐ Day dreaming

☐ Frequent worry
☐ Racing thoughts
☐ Difficulty concentrating or thinking
☐ Flashbacks
☐ Thoughts of harming or killing someone else
☐ Thoughts of harming or killing self
☐ Intrusive memories
☐ Large gaps in memory
☐ Nightmares
☐ Intentional self-harm

Does child have access to firearms or weapons? ☐ Yes ☐ No If yes, are the firearms/weapons locked up or otherwise secured? ☐ Yes ☐ No

---

☐ Feeling puzzled as to what is real and unreal
☐ Persistent, repetitive, intrusive thoughts, impulses or images
☐ Unusual visual experiences such as flashes of light, shadows
☐ Hear voices when no one else is present
☐ Feeling that thoughts are controlled or placed in his/her mind
☐ Difficulty problem solving
☐ Dependency on others
☐ Inappropriate expressions of anger
☐ Difficulty or inability to say "no" to others
☐ Sense of lack of control
☐ Abusive relationship
☐ Concerns about his/her sexuality
☐ Difficulty meeting role expectations
☐ Manipulation of others to fulfill own desires
☐ Self-mutilation/cutting
☐ Ineffective communication
☐ Decreased ability to handle stress
☐ Difficulty expressing emotions

Stressors:

Has he/she experienced any of the following stressors? (Check all that apply)

☐ Recent move
☐ Job change
☐ Change in schools
☐ Financial problems
☐ Personal/Family health problems
☐ Marriage
☐ Divorce
☐ Violence
☐ Death
☐ Substance abuse

☐ Other (please explain____

Has child been exposed to domestic violence? ☐ Yes ☐ No

Please describe any other symptoms or experiences you have had problems with:

____

____

Past Psychiatric History

Has he/she ever met with a mental health professional in the past? ☐ Yes ☐ No If so, please list the names of any treatment providers, their specialty (e.g. psychologist), and time period for treatment: ____

____

____

Is he/she **CURRENTLY** taking **PSYCHIATRIC** medication? ☐ Yes ☐ No If YES, please list:

Medication	Dosage	How long have you been taking it?	Has it been helpful?

Has he/she been on **PSYCHIATRIC** medication in the past? ☐ Yes ☐ No If YES, please list:

Medication	Dosage	First/Last time you took it:	Effect of medication

Has he/she ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No If YES, describe:

Hospital	Dates	Reason

Has he/she ever tried to harm him/herself? ☐ Yes ☐ No If YES, please describe the incident, the stressors, and when the incident occurred: ____

____

____

Medical History

Is the primary care physician aware of this appointment? ☐ Yes ☐ No

Date of last exam? ______________________

May we contact him or her? ☐ Yes ☐ No
Are immunizations up to date? ☐ Yes ☐ No

Preferred Pharmacy:

Name:___________________________ Phone number________________________

Does he/she have any known **ALLERGIES** to any medications? ☐ Yes ☐ No If yes, please list all medications that have caused an allergic reaction and describe the reactions to each one:

____
____

Is he/she **CURRENTLY** under treatment for any medical condition? ☐ Yes ☐ No
If YES, please describe: ____
____

Is he/she **CURRENTLY** taking **NON-PSYCHIATRIC** medication? ☐ Yes ☐ No

Medication	Dosage	How long has he/she been taking it?

List any **PRIOR** illnesses, operations and accidents: ____________________________________
____
____

Social History:

Birth/Early Infancy History:

This information should be provided as it relates to the biological parents of the child, if known.
Was the pregnancy planned? ☐ Yes · No ☐ Unknown
Any difficulty becoming pregnant? ☐ Yes☐ No If yes, please explain ________________________
____
____

Was the mother exposed to any of the following while pregnant: ☐ None ☐ Unknown

Type	List Specific Substances	Amount	Month of pregnancy
Drugs			
Alcohol			
Tobacco			
Medications			
X-rays			

Did the mother experience any significant illnesses during pregnancy? ☐ Yes ☐ No ☐ Unknown
If yes, please provide details: ____
____
____

Length of pregnancy:___________Age of mother:_____________Weight gain: ____________

Labor and/or delivery with this child: ☐ Easy ☐ difficult ☐ Natural ☐ C-section ☐ Forceps

Please provide details on any labor/delivery problems: ______________________________________
____

Were there any problems while the baby was still in the hospital? (e.g., prolonged jaundice, need for incubator/oxygen, infections, feeding problems, convulsions): ______________________
____
____

Were there any difficulties during the baby's infancy? (e.g., excessive crying, health problems, recurrent vomiting, "colic," poor suck, low weight gain): __________________________________
____
____

Development:

Do you have any concerns about your child's development? ☐ Yes ☐ No

Has your child had any formal developmental testing or received any early intervention services?

☐ Yes ☐ No If yes, please provide details: ____
____
____

Has your child ever been diagnosed or suspected of having Autism, communication/learning difficulties or any other developmental delays? ☐ Yes ☐ No if yes, please explain:

____
____
____

Please identify your child's developmental progress in the following areas:

Area of Development:	Same as Others	Slower	Faster	Comments
Gross Motor Skills (running, throwing a ball, bicycling)	☐	☐	☐	
Fine Motor Skills (coloring, drawing, writing, scissor use)	☐	☐	☐	
Speech and Language Skills				
1. Social communication	☐	☐	☐	
2. Pronunciation, vocabulary	☐	☐	☐	
Self-Control *Skills* (impulse control, delaying gratification)	☐	☐	☐	
Self-Concept (child's opinion of self, abilities, worth)	☐	☐	☐	
Cognitive Skills	☐	☐	☐	

Where was he/she raised?___________________________ Was he/she adopted? ☐ Yes ☐ No
If so, how did that come to be? ____
____

Who currently lives in the household with the child other than the caregivers listed above?

Name	Gender	Age	Relationship

Biological Father: Age: ☐ Living ☐ Deceased Cause of death:
Occupation: If deceased, HIS age at time of his death:

Health: Child's age at time of his death:
Frequency of contact with him:
Describe his/her relationship with their father: ____
____

Biological Mother: Age: ☐ Living ☐ Deceased Cause of death:
Occupation: If deceased, HER age at time of her death:

Health: Child's age at time of her death:
Frequency of contact with her:
Describe his/her relationship with their mother: ____
____

Did parents divorce? ☐ Yes ☐ No If yes, how old was child? _______________
Did father remarry? ☐ Yes ☐ No If yes, how old was child? _____________
Did mother remarry? ☐ Yes ☐ No If yes, how old was child? _______________

Has anyone in the immediate family ever died? ☐ Yes ☐ No If so, who and when? ________
____
____

Siblings/Other Family/Important long-term Friends:

Name	Sex	Age	Relationship	Whereabouts	Is child close to him/her?	
					Yes	No
					Yes	No
					Yes	No
					Yes	No
					Yes	No

Has child lived with anyone other than their natural parents for any significant period of time?
☐ Yes ☐ No If YES, please list name and relationship:
Name:___________________________________ Relationship:_____________________________
Name:___________________________________ Relationship: _____________________________
Has he/she ever been abused?

☐ Verbally ☐ Emotionally ☐ Physically ☐ Sexually ☐ Neglected
Please describe: ____
____

Has abuse/neglect been documented by CPS/Legal System? ☐ Yes ☐ No

Has the abuse history been previously addressed by a professional? ☐ Yes ☐ No

How much time does your child typically spend on electronic media per day?
Watching TV: ___________ Playing video games: ___________ Other: ___________

Please describe forms of discipline used in the home and their effectiveness: ___________________
____
____

Please list those qualities about your child that you consider to be strong **positive** points: ________

____

Please list those qualities about your child that you consider to be strong **negative** points: _______

____

Does your child have any attachment or bonding difficulties with a history of disrupted parenting before age 5? ☐ Yes ☐ No If yes, please explain: ______________________________________

____

Religion

What is child's religious affiliation? _______________

Please rate the importance of religion or spiritual beliefs in his/her life:

All important Very important Important Somewhat important Not important

Education

Is patient currently enrolled in school? ☐ Yes ☐ No

Please indicate your child's attendance in the current and past quarter of school:

On average, my child is missing less than/more than (circle one) one day per week of school.

Teacher/Counselor/IEP Coordinator: ____

Is child enrolled in special education? ☐ Yes ☐ No

Child is designated: ☐ Serious behavioral disorder ☐ Learning disordered ☐ Health impaired

Child's classroom is: ☐ Regular Education ☐ Self-contained classroom

☐ Special education classroom ☐ Inclusion in regular education (____hours/day) ☐ Other

Describe current daily functioning in school setting, including strengths and needs: ____________

____

Does child enjoy school? ☐ Yes ☐ No

What things got him/her in trouble in school? ____

What kinds of grades does child get in school? ________________

Please indicate if your child has had any trouble in school with the following:

☐ Peer relations ☐ Behavior ☐ Academic ☐ Relationship to teacher

Describe child's social life at school: ____

____

Please include copies of individual education plans (IEP, 504, etc.) school/psychological testing and report cards for this child.

Family Medical History

Please check the appropriate box if there are or have been present in child's *biological* relatives:

	Brothers	Sisters	Father	Mother	Uncle/Aunt	Grandparent
Anxiety						
OCD						
PTSD						
ADHD						
Bipolar						
Schizophrenia						
Depression						
Substance abuse						
Counseling						
Psychiatric Medication						
Psychiatric Hospitalization						
Suicide attempt						
Death by suicide						

Answer this section only as it pertains to the patient.
Relationship Status: ☐ single ☐ married ☐ dating ☐ boy/girlfriend ☐ engaged ☐ cohabitating
How long in current status: ____________________
If applicable: Partner's name:______________________________Partner's Age: __________
Partner's occupation: ______________________________________

Describe his/her relationship with their significant other: _________________________________
____

Does he/she have children? ☐ Yes ☐ No Names and ages: _____________________________
____

What kind of social activities does he/she participate in (e.g. sports, church)? ________________
____
____

Employment Is he/she employed? ☐ Yes ☐ No If yes, employer's name: __________________________

What type of work does he/she do? ____

What was his/her last job and the longest job they ever held?

Type of Job	Dates	Reason for Leaving

Legal

Has he/she ever been involved in the legal system? ☐ Yes ☐ No If yes, please check all that apply:

☐ Juvenile Justice ☐ Arrests ☐ Truancy ☐ Substance abuse ☐ At-risk youth

☐ Other: ____

Substance Abuse:

Do any of his/her friends drink alcohol, smoke or use drugs? ☐ Yes ☐ No

Does he/she use tobacco? ☐ Yes ☐ No If yes, how much? ______________________

Does he/she drink alcohol? ☐ Yes ☐ No

How often does he/she drink? _________________________

How much does he/she drink? _________________________

Has he/she ever passed out from drinking? ☐ Yes ☐ No

Has he/she ever blacked out from drinking? ☐ Yes ☐ No

Have you ever felt you should cut down on your drinking/drug use? ☐ Yes ☐ No

Has he/she ever experienced legal problems (including arrest) due to alcohol/drug use?

☐ Yes ☐ No If yes, please explain: ____

____

Other drugs

Please indicate for each drug listed below:

Drug	Ever used?	Age at 1st use	Time since last use	Approximate use in last:		Comments: Effect of drug, drug of choice, bad trips?
				30 days	Year	
Alcohol						
Marijuana						
Inhalants						
Cocaine/Crack						
Methamphetamine						
Heroin						
LSD/Shrooms						
Ecstasy						
Prescribed pills						
Other						

Is there anything else you would like us to know about your child that was not asked?

____

____

____

____