Children & Youth Assessment

Child/Youth's Name: _____ DOB: _____

Father's Name: _____ Occupation: _____

Employer: _____ Highest Level of Education: _____

Mother's Name: _____ Occupation: _____

Employer: _____ Highest Level of Education: _____

List other members of the household and their relationship to the child:

Name	Relationship	Age	School & Grade	Learning or Behavioral Issues

Primary Care Proiver/ Pediatrician : _____

Has the child experienced any of the following?

□ Moving? How many times? _____ When? _____

□ Long visits with relatives? If so, whom? _____ When? _____

□ Living with someone other than a parent If so, whom? _____ When? _____

□ Death in the family If so, whom? _____ When? _____

□ Terminal or chronic illness If so, whom? _____ What type of illness? _____

□ Parental separation and/or divorce When? _____

□ New step-parent Which parent re-married? _____ When? _____

□ Other traumatic or upsetting experience Explain: _____

DEVELOPMENTAL HISTORY

PREGNANCY & DELIVERY:

Prenatal Care: ☐ Adequate ☐ Inadequate ☐ Unknown

Significant illnesses (mother): _____

Perinatal Events: Was child premature? ☐ Yes ☐ No ☐ Unknown

Birth Weight: _____ Birth Height: _____

Birth Complications? ☐ Yes ☐ No ☐ Unknown If Yes, explain: _____

FIRST YEAR:

Breast Fed? ☐ Yes ☐ No ☐ Unknown If Yes, how long? _____

Allergies? ☐ Yes ☐ No ☐ Unknown If Yes, explain: _____

Problematic Sleep Patterns? ☐ Yes ☐ No ☐ Unknown If Yes, explain: _____

MILESTONES: (Give approximate age if known)

_____ Sat without Support _____ Crawled _____ Walked with Assistance

_____ Ate with a Fork _____ Toilet Trained _____ Able to Dress Self

_____ Said first Word _____ Used Sentences

If unable to remember specific dates, were milestones reached Within Normal Limits? ☐ Yes ☐ No ☐ Unknown

Prenatal History

Did the mother receive regular prenatal care? ☐ Yes ☐ No

Were there any illnesses or problems during pregnancy for the child or the mother? ☐ Yes ☐ No

Explain: _____

Were any medications or drugs taken during pregnancy? ☐ Yes ☐ No

Explain: _____

Does the child have difficulty with any of the following:

☐ Balance ☐ Throwing a ball ☐ Skipping ☐ Writing/coloring ☐ Buttoning ☐ Memory

☐ Following instructions ☐ Understanding what others are saying ☐ Paying attention/staying focused

Explain: _____

MEDICATION

Is the child currently taking any medications? ☐ Yes ☐ No If Yes, please list medication

Medication Physician Reason How long has the child been taking this medication?

_____

_____

_____

Has the child ever been prescribed any additional medication for conditions other than common childhood illnesses?

_____

Has anyone in the child's family been diagnosed as having any chronic medical or emotional disorders?

Explain:

Did either of the child's parents have a learning disability or behavior concerns during childhood?

Explain:

Social-Emotional History

Did the child attend pre-school? ☐ Yes ☐ No If so, where and when? _____

Where does the child attend school? _____ Grade? _____

Does the child have an IEP? ☐ Yes ☐ No Reason: _____

Who handles the discipline in the home? _____

What methods of discipline are most effective with the child? _____

Does the child exhibit any of these behaviors frequently at home or within the community?

☐ Shyness ☐ Unable to make/keep friends ☐ Prefers to play alone ☐ Cries easily ☐ Irritable

☐ Very Independent ☐ Fearful ☐ Harms pets/animals ☐ Plays with sex organs or other body parts

☐ Insists on his/her own way ☐ Physical ailments/complaints ☐ Unable to show feelings ☐ Indecisive

☐ Threatens to harm self ☐ Threatens to harm others ☐ Shows preoccupation with fire ☐ Nightmares

☐ Hand waving or flapping ☐ Runaway ☐ Rocking ☐ Head banging ☐ Quick temper ☐ Bites

☐ Lies, steals, and/or cheats ☐ Difficult to discipline ☐ Nail biting ☐ Thumb sucking ☐ Talks baby talk

☐ Overactive ☐ Always worried ☐ Daydreams ☐ Easily distracted ☐ Destructive ☐ Accident prone

☐ Other unusual behavior_____

If so, explain: _____

Has this child ever seen a counselor (including a school counselor)? ☐ Yes ☐ No

If so, list the names and contact numbers for any providers or professionals who have pertinent information about your child (i.e.- pediatrician prescribing psychotropic medications, community mental health agencies, school counselor, etc.).

Severity Measure for Depression—Child Age 11–17*

*PHQ-9 modified for Adolescents (PHQ-A)—Adapted

Name:_____ **Age:** _____ **Sex: Male** ☐ **Female** ☐ **Date:**_____

Instructions: How often have you been bothered by each of the following symptoms during the past 7 days? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

						Clinician Use
						Item score
		(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day	
1.	Feeling down, depressed, irritable, or hopeless?					
2.	Little interest or pleasure in doing things?					
3.	Trouble falling asleep, staying asleep, or sleeping too much?					
4.	Poor appetite, weight loss, or overeating?					
5.	Feeling tired, or having little energy?					
6.	Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?					
7.	Trouble concentrating on things like school work, reading, or watching TV?					
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?					
9.	Thoughts that you would be better off dead, or of hurting yourself in some way?					
					Total/Partial Raw Score:	
					Prorated Total Raw Score: (if 1-2 items left unanswered)	

Modified from the PHQ-A (J. Johnson, 2002) for research and evaluation purposes

Severity Measure for Generalized Anxiety Disorder—Child Age 11–17

Name:_____ Age: _____ Sex: Male ☐ Female ☐ Date:_____

Instructions: The following questions ask about thoughts, feelings, and behaviors, often tied to concerns about family, health, finances, school, and work. **Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
	During the **PAST 7 DAYS**, I have...	Never	Occasionally	Half of the time	Most of the time	All of the time	Item score
1.	felt moments of sudden terror, fear, or fright	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
2.	felt anxious, worried, or nervous	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
3.	had thoughts of bad things happening, such as family tragedy, ill health, loss of a job, or accidents	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
4.	felt a racing heart, sweaty, trouble breathing, faint, or shaky	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
5.	felt tense muscles, felt on edge or restless, or had trouble relaxing or trouble sleeping	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
6.	avoided, or did not approach or enter, situations about which I worry	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
7.	left situations early or participated only minimally due to worries	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
8.	spent lots of time making decisions, putting off making decisions, or preparing for situations, due to worries	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
9.	sought reassurance from others due to worries	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
10.	needed help to cope with anxiety (e.g., alcohol or medication, superstitious objects, or other people)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
						Total/Partial Raw Score:	
						Prorated Total Raw Score: (if 1-2 items left unanswered)	
						Average Total Score:	

iMind Mental Health and Wellness
Appointment Cancellation and No-Show Policy

Thank you for trusting iMind Mental Health and Wellness to provide services for your mental health needs. When you schedule an appointment, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office 24 hours prior to your appointment.

New Patients

Any new patient who fails to show for their initial visit will not be rescheduled.

Established Patients

Effective February 1st, 2018 any established patient who fails to cancel their appointment 24 hours prior to their visit will be charged a $25.00 No Show fee.

Established patients who fail to cancel their appointment 24 hours prior to their visit for a second time will be charged a $50.00 No Show fee.

No Show fees must be paid PRIOR to scheduling a follow up appointment.

Any patient who fails to cancel their appointment 24 hours prior to their visit for a third time will be discharged from iMind Mental Health and Wellness.

We understand there may be times when an unforeseen emergency may occur, and you may not be able to keep your scheduled appointment. If you experience extenuating circumstances, please contact our Office Manager at 731-300-0810.

iMind Mental Health and Wellness, LLC

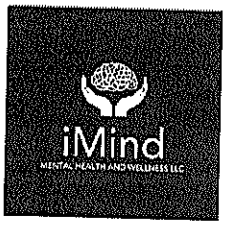
I have read and understand the Mental Health Appointment Cancellation/No Show policy and agree to its terms.

_____

Signature of Patient/Legal Guardian Date

_____

Printed Name Date



iMind Mental Health and Wellness
New Patient Intake Cancellation/No Show Policy

New Patients

Any new patient who fails to show for their initial consult or cancels the initial consult with Aaron Brakhane will be charged a $50 rescheduling fee that must be paid PRIOR to rescheduling the initial consultation.

Established Patients

Effective February 1st, 2018 any established patient who fails to cancel their appointment 24 hours prior to their visit will be charged a $25.00 No Show fee.

Established patients who fail to cancel their appointment 24 hours prior to their visit for a second time will be charged a $50.00 No Show fee.

No Show fees must be paid PRIOR to scheduling a follow up appointment.

Any patient who fails to cancel their appointment 24 hours prior to their visit for a third time will be discharged from iMind Mental Health and Wellness.

Patient Telehealth Consent Form

Thank you for the opportunity to serve you! We look forward to becoming your partner in your health care and understanding your health care needs better.

Please review the follow consents PRIOR to your visit with us. We will ask you during the initial visit if you had the opportunity to review the consents and allow you the opportunity to ask any questions.

General Consent for Care and Treatment. I have the right, as a patient, to be informed about my condition and the recommended surgical, medical or diagnostic procedure to be used so that I may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in my care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By my verbal consent, I am indicating that (1) I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) I consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked. I have the right at any time to discontinue services.

I have the right to discuss the treatment plan with my physician about the purpose, potential risks and benefits of any test ordered for me. If I have any concerns regarding any test or treatment recommend by my health care provider, I am encouraged to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Consent to Treatment Using Telemedicine. I consent to treatment involving the use of electronic communications to enable health care providers at different locations to share my individual patient medical information for diagnosis, therapy, follow-up, and/or education purposes. I consent to forwarding my information to a third party as needed to receive telemedicine services, and I understand that existing confidentiality protections apply. I acknowledge that while telemedicine can be used to provide improved access to medical care, as with any medical procedure, there are potential risks and no results can be guaranteed or assured. These risks include, but are not limited to: technical problems with the information transmission; equipment failures that could result in lost information or delays in treatment. I understand that I have a right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

Patient Consent for Financial Communications

Financial Agreement. I acknowledge, that as a courtesy, the practice may bill my insurance company for services provided to me. I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance. I understand there is a fee for returned checks.

Third Party Collection. I acknowledge the practice may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to the practice any insurance or other third-party benefits available for health care services provided to me. I understand the practice has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to the practice, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the practice by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for the practice, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that the practice or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or the practice or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Patient Consent and Acknowledgement form for Privacy

Notice of Privacy Practice/clinics. I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members. I may give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others. I will communicate the Name, Relationship, and contact information to the clinical team to ensure it is documented.

Communications about My Healthcare. I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

Consent for Photographing or Other Recording for Security and/or Health Care Operations. I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications. **If at any time I provide an email address or cellphone number** at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from

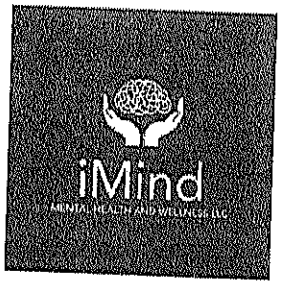
that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.
Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Release of Information. I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.



Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____ Security code: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize_____to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date