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Child/Adolescent History Questionnaire

Please answer as completely as you can and return this form at their scheduled appointment.

Today's Date:	Appointment Date:
How did you hear about Lakes Psychiatric Center?	

Name	Age	Sex	Date of Birth
Primary address	Alternate address		
Parent's/Guardian's names	If divorced then list legal custodian(s)		
Siblings first names and ages	Step siblings and ages		
Lives with full time ☐ or	shared with (please list schedule) ☐		

Check boxes below for what numbers we can leave messages on. May we send discrete appointment reminders to your email? YES ☐ NO ☐	Primary email ☐		
Main Home Phone ☐	Mom/Guardian Cell ☐	Dad/Guardian cell ☐	Secondary email address ☐
School Name and District	Grade	Pediatrician/Office Name	
Employed ☐ Fulltime Student ☐ Part-time Student ☐ Unemployed / Other ☐ _____			
Religion	Ethnicity		

INSURANCE or NONE ☐

Primary Insurance Company	Contract Number	Group Number
Name and address of Subscriber	Subscribers Date of Birth	Relationship to Subscriber
Employer	Effective Date	Mental Health Provider
Secondary Insurance Company	Contract Number	Group Number
Name and address of Subscriber	Subscribers Date of Birth	Relationship to Subscriber
Employer	Effective Date	Mental Health Provider

PRESENTING PROBLEM

What is the problem that brought you/them to LPCC? _____

When did this issue begin? _____

Is there a prior history of these issues? YES ☐ NO ☐ For how long? _____

Does it effect: Family? YES ☐ NO ☐ Friends? YES ☐ NO ☐ School? YES ☐ NO ☐ Leisure Time? YES ☐ NO ☐

Name three (3) things you/they would like changed in the current situation:

1. _____
2. _____
3. _____

MENTAL HEALTH HISTORY

Have you/they ever had a significant period of time in which you/they have experienced:

Serious Depression? YES ☐ NO ☐ If yes, explain: _____

Serious Anxiety? YES ☐ NO ☐ If yes, explain: _____

Hallucinations? YES ☐ NO ☐ If yes, explain: _____

Trouble understanding, concentrating or remembering? YES ☐ NO ☐ If yes, explain: _____

Any academic or psychological testing in the past? YES ☐ NO ☐ Done by whom? _____

If yes please provide copies of the results _____

IEP/Special Education? YES ☐ NO ☐ If yes then what is the certification:

Trouble controlling aggressive behavior? YES ☐ NO ☐ If yes, explain:

Serious thoughts of suicide? YES ☐ NO ☐ If yes, explain: _____

Self- harm behaviors? (ex. cutting, skin picking, hair pulling) YES ☐ NO ☐ Explain:

Have you/they experienced abuse? Physical ☐ Emotional ☐ Sexual ☐ Other ☐

Explain:

What treatment have you/they had in the past for these issues?

Talk Therapy ☐ Explain: _____

Family Therapy ☐ Explain _____

Hospitalization/Day Treatment ☐ (approx. year and reason):

Would you like us to request copies of the records? YES ☐ NO ☐ If yes - ask to sign a release and bring the contact info

MEDICATIONS

List **all *current*** medications or over the counter medications. (use an additional page if needed)

Medications ☐ ***CHECK IF LISTED ON ANOTHER PAGE***

Medication	Dose	Frequency	How Long?	For	Prescribed by: PCP	Psychiatrist
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐

List any ***previous*** **psychiatric** medications. (use an additional page if needed)

Medication	Highest Dose	Was it effective?	Side effects	Prescribed by: PCP	Psychiatrist
				☐	☐
				☐	☐
				☐	☐

OFFICE USE – MEDICATIONS _____

MEDICAL HISTORY

Present state of general physical health: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Current weight _____ Growth on track? _____ Puberty? _____ Age _____

Do you/they play sports: YES ☐ NO ☐

describe _____

Describe your/their present eating pattern: _____

Describe your/their present sleeping pattern (hours per night, problems getting to sleep or waking early, night terrors, sleepwalking):

Do you/they have any current medical problems? YES ☐ NO ☐

Explain: _____

Have you/they ever had HEAD INJURY ☐ SEIZURES ☐ SEVERE FOOD ALLERGY ☐

Explain: _____

List any significant hospitalizations or surgeries: _____

Did you/they have childhood immunizations? _____

ALLERGIES: Check here if NONE ☐

OFFICE USE – MEDICAL/ALLERGIES _____

PARENT'S RELATIONSHIP HISTORY

Never Married ☐ Married ☐ How Long? _____ Separated ☐ Widowed ☐ Divorced ☐

Living Together ☐ How long? _____

Quality of relationship?

Previously Married? YES ☐ NO ☐

If yes, length of marriage/how long/any conflicts with ex-spouse/children?

Please describe issues/stressors regarding parenting time, blended family issues, or other relevant information

DEVELOPMENT

Name (child's parents and siblings)	Relationship	Age	Quality of Relationship	Mental Disorder
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐
				YES ☐ NO ☐

If mental health issues then what type? _____

List any other relatives with a history of emotional or mental disorder or suicide (include diagnosis and treatment if known):

Any exposure to alcohol or drugs during pregnancy? YES ☐ NO ☐ UNK ☐
Any exposure to tobacco products during pregnancy? YES ☐ NO ☐ UNK ☐
Did your/their mother have any problems during pregnancy? YES ☐ NO ☐ UNK ☐
Did your/their mother have any problems during labor or delivery? YES ☐ NO ☐ UNK ☐
Birth weight? _____
Did you/they have any problems immediately after birth? YES ☐ NO ☐ UNK ☐
Did you/they have any developmental delays? YES ☐ NO ☐ UNK ☐
Do you/they have any specific learning issues in school? YES ☐ NO ☐ UNK ☐
Do you/they have an IEP? YES ☐ NO ☐ since what grade? _____
Are you/they: Frequently sick ☐ Frequently absent ☐ Suspended ☐ Expelled ☐ Bullied ☐
If yes explain: _____

Current grade: _____ Typical Grades: _____
Describe interests, habits or fears: _____

Do you/they have close friends? Social issues? Fears? _____

OFFICE USE – FAMILY/PARENTS/DEVELOPMENT _____

LEGAL ISSUES

Any past or present court or legal problems? YES ☐ NO ☐ If YES, please explain: _____

SUBSTANCE USE HISTORY or NONE ☐

Indicate the amount and frequency of use of the following:

	Amounts	Frequency	Currently using?	How Long?
Alcohol			YES ☐ NO ☐	
Nicotine			YES ☐ NO ☐	
Caffeine			YES ☐ NO ☐	
Marijuana			YES ☐ NO ☐	
Illicit Drugs			YES ☐ NO ☐	
Prescription/Pain meds			YES ☐ NO ☐	

Indicate substance(s) of preference:

Any prior treatment and was it prompted/ordered by criminal justice system (ex. MIP)? YES ☐ NO ☐ _____

Have any of your relatives ever had a serious problem with drugs or alcohol? YES ☐ NO ☐

If so, relative: _____ Substance: _____

If so, relative: Substance:

Check any of the following words or terms that have applied to your child/teen **Currently** or in the **Past**

	Current	Past
Headaches		
Stomach aches		
Bowel disturbances		
Gets angry easily		
Nightmares		
Hard time sleeping		
Won't sleep in own bed		
Problems being away from caregiver		
Worries a lot/nervous		
Shy		
Difficulty making friends		
Low self esteem		
Sad/depressed		
Quick changes in mood		
Hears/sees things that aren't there		

	Current	Past
Skips/won't go to school		
Hard time concentrating		
Overactive		
Underactive		
Short attention span		
Forgetful		
Unable to sit still		
Acts younger than expected		
Likes order and routine		
Acts before thinking		
Bangs head		
Sucks thumb		
Hits self		
Twitches, jerks or shakes		
Doesn't keep self clean/refuses to bathe		

	Current	Past
Won't follow rules		
Talks back/defiant		
Gets into fights		
Lies		
Steals		
Is never sorry		
Argues frequently		
Problems making and keeping friends		
Hurts animals		
Tantrums		
Throws/breaks things		
Hits other kids or adults		
Yells and screams		
Sets fires		
Acts in sexually inappropriate ways for age		

_____ _____

Adolescent signature (if they completed the form) Date

_____ _____

Parent/Guardian signature Date

_____ _____

Reviewing LPCC Staff Date

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Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed, aand how you can obtain access to this information. Please review it carefully.

Our staff uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of our organization.

We May Use or Disclose Your Health Information for:

Treatment: We may use your health information to provide you with mental health treatment or services. For example, information obtained by a mental health provider, such as a psychiatrist, psychologist, social worker, or other person providing mental health services to you, *will* record information in your record that is related to your treatment. This information is necessary for mental health providers to determine what treatment you should receive. Mental health providers *will* also record actions taken by them in the course of your treatment and note how you respond to the actions.

Payment: We may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you of a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment or service.

Health Care Operations: We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the clinical staff, risk or quality improvement personnel, and others to:

- evaluate the performance of staff;
- assess the quality of care and outcomes in your cases and similar cases;
- learn how to improve our facilities and services; and
- determine how to continually improve the quality and effectiveness of the mental health care we provide.

Appointments: We may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services char may be of interest to you.

Required by Law: We may use and disclose information about you as required by law. For example, we may disclose information for the purposes:

- for judicial and administrative proceedings pursuant to legal authority;
- to report information related to victim of abuse, neglect or domestic violence; and
- to assist law enforcement officials in their law enforcement duties.

Public Health: Your health information may be used or disclosed for public health authorities or other legal authorities to prevent or control disease, injury, or disability or for other health oversight activities.

Descendents: Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation: Your health information may be used or disclosed for cadaveric organ, eye or tissue donation.

Research: We may review your mental health information to determine if your protected health information is needed for research projects. To the e extent that information is needed, an institutional review board or privacy board will review the research proposal and established protocols to ensure the privacy of your health information.

Health and Safety: Your health information may be disclosed to avert a serious threat to the health and safety of you or any other person pursuant to applicable law.

Government Functions: Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed forces.

Workers' Compensation: Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

Other uses : Uses and disclosures will be made only with your written authorization and you may evoke the authorization except to the extent we have relied on it.

Your Health Information Rights

You have the right to:

- request restriction on certain uses and disclosures of your information as provided; however, we are not required to agree to a requested restriction;
- to obtain a paper copy of this notice of Privacy Practices upon request;
- inspect, and obtain a copy of your health record as provided by law;
- request communications of your health information by alternative means or at alternative locations;
- revoke your authorization to use or disclose health information except to the extent we have already taken action based upon your authorization; and
- receive an accounting of disclosures made of your health information.

If you have any questions or complaints, please contact the Privacy Official at 248-266-4266. You may also complain to the Department of Health and Human Services if you believe your privacy rights have been violated. You *will* not be retaliated against for filing a complaint.

We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain.

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Practice Orientation and Agreement

Your Rights and Responsibilities as a Client:

- You have the right to receive services from clinicians who adhere to the professional code of ethics of their respective disciplines.
- You have the right to receive services in accordance with Federal and State regulations and accreditation standards governing behavioral health programs.
- You have the right to privacy and confidentiality regarding the services you receive. All information about you and your treatment, whether written or oral, is protected under Federal and State laws, including the HIPAA Privacy Act.
- You have the responsibility to provide informed consent to services offered to you.
- You have the right to refuse services at any time. You have the right to withdraw your consent to receive services and discontinue services at any time. If you should decide to withdraw your consent for services, you must do so in writing.
- You have a right to information concerning your treatment and/or care.
- You have the right to know treatment recommendations and the possible outcomes if you choose not to follow these recommendations.
- You have the responsibility to assist in planning your treatment at every stage.
- You have the right to express any concerns or complaints regarding the services you receive. We encourage you to first contact your clinician to resolve any issues. You may also contact the Director for assistance.
- You have the responsibility to be timely for your appointments. Late arrivals *may* result in rescheduled appointments.
- You have the responsibility to arrive for all scheduled sessions, or to notify us 24 hours in advance if you wish to cancel an appointment. You *may* be charged a practice fee, up to $100, for non-cancelled appointments where an emergency was not involved, as insurance companies and other third-party payers do not cover missed appointments.
- You are responsible for checking your insurance plan benefits, including any deductibles and/or co-pays. As a courtesy, we attempt to check eligibility and benefits for you.
- You are responsible for any fees that may be charged to you at the time of service and knowing your insurance benefits coverage. You will be charged $25 for any returned checks.

Services Offered:

Lakes Psychiatric Center offers an array of mental health and substance abuse services. These services include: individual psychotherapy, group therapy, family therapy, marital therapy, psychiatric evaluations and medication therapy. Your clinician will provide you with a detailed description of the nature of services, expected benefits and potential risks.

Operations:

Appointments may be individually arranged from 8:00 am and 10:00 pm, 7 days a week. Not all clinicians are available during all open hours. Office staff will generally be available from 9am-5 pm Mon through Friday. Appointment dates and times, and after-hours contact, will be arranged between you and your treating clinician. In the case of an emergency, you can contact the nearest crisis center (Oakland County Crisis Line at 800-231-1127) or you may visit the nearest emergency room. We practice in a non-smoking environment. Illicit drugs and weapons are not allowed on the premises. Persons in possession of either will be asked to leave immediately.

Confidentiality:
Federal and State laws protect the privacy of communications between a client and a clinician. In most situations, information about your treatment can only be released to others if you sign a written Consent for Release of Confidential Information. However, there are some limits to confidentiality. Information about privacy and limits to confidentiality will be provided by your primary clinician and are also provided in our Notice of Privacy Practices.

Financial Responsibility:

You are expected to pay for service at the time it is rendered, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. A fee adjustment or a payment installment plan may be negotiated in circumstances of unusual financial hardship. All clients will be informed of payment fee schedules prior to rendering services. Although we are likely to inform you of your insurance deductible and co-pays, you are ultimately responsible for knowing this information and for paying both in full.

If your account has not been paid for more than 90 days, and arrangements for payment have not been agreed upon, legal action may be used to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require disclosure of otherwise confidential information. In most collection situations, the only information released regarding a client's treatment is his or her name, the nature of services provided, and total amount due. If such legal action is necessary, its cost will be included in the claim.

Minors and Parents:
Clients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. They should also be aware that clients over age 14 can consent to (and control access to information about) their own mental health treatment, although that treatment cannot extend beyond 12 sessions or 4 months. While privacy is very important, particularly with teenagers, parental involvement is also essential to successful treatment. Therefore, it is Lakes Psychiatric Center policy to request (but not require) an agreement from any client between ages 14 and 18 and their parents allowing clinicians to share general information with parents about attendance at scheduled sessions and progress in treatment.

Consent for Services:
My initials below indicate that I:

_____ have been made aware of my rights and responsibilities and how to file a grievance or complaint.

_____ have been informed of the name, discipline, and credentials of my primary clinician.

_____ have been informed of practice-specific information and given an orientation to services and give permission to bill my insurance and agree to pay out of pocket costs at the time of the appointment.

_____ have been informed of privacy practices, confidentiality, and limits to confidentiality.

My signature below indicates that I consent to receive services at Lakes Psychiatric Center, and that I understand I may discuss any questions I have regarding services and that I maintain the option to terminate my consent at any time.

_____ _____
Client Signature Date Parent/Guardian Signature Date

_____
Lakes Psychiatric Center Staff Date

Primary Care Physician Notification Form

THIS IS **NOT** A REQUEST FOR MEDICAL RECORDS!

ATTENTION PRIMARY CARE PROVIDER: Your patient is being seen at
Lakes Psychiatric Center 2300 Haggerty Rd Ste 2160, W.Bloomfield, MI 48323 ph 248-859-2457 fax 248-859-2473
With patient authorization, we herein provide diagnoses and medications, including medication changes.
Please retain for your records.

Patient Name:_____

DSM Diagnoses (Including Codes):_____

_____

Treatment Information, including medication:_____

_____

_____

_____

Therapist/Psychiatrist Signature Print Name and Credentials

TO THE PATIENT:

If you **do want** to notify your primary care/family doctor that you are receiving services, please provide the complete name and address of your Primary Care Physician:

Primary Care Physician:_____ Phone ( )_____

Clinic Name (if any):_____ Fax (_____

Address: _____

City, State, Zip: _____

Please read and complete the following:

(Name) _____ DOB:_____ authorizes Lakes Psychiatric Center to exchange information regarding my mental health and/or substance abuse treatment and medical health care for the purpose of continuity of care as may be necessary for the administration and provision of my health care coverage. Information exchanged may include information on mental health care or substance abuse treatment as protected under 42 CFR Part 2 (respecting substance abuse records) and/or state laws respecting confidentiality of records and patient communications with health care providers and in compliance with HIPAA regulations. I understand that this authorization shall remain in effect for one year or throughout the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the LPCC. I also understand that it is my responsibility to notify by behavioral health care provider if I choose to change my primary care physician.

If you do not want to authorize us to notify your primary care/family doctor, please complete the section below:

_____ I don't have a primary care/family doctor.

_____ I don't want my primary care/family doctor to know I'm receiving services.

_____ I just don't want to.

_____ _____

Patient Signature (or Parent/Guardian if patient is a minor) Date

_____ _____

Witness Signature Date