# PATIENT INFORMATION AND MEDICAL HISTORY FORM

**PATIENT DEMOGRAPHICS**

Preferred Called Name:_____ Age:_____

Last Name:_____ First Name:_____

Date of Birth:_____ Social Security Number:_____

**CONTACT**

Home:_____ Work:_____ Cell:_____

May we leave a detailed message? ☐ Yes ☐ No IF YES, please circle the preferred number.

Email:_____

May we email you for appointment reminder, confidential results, promos, etc? ☐ Yes ☐ No

Preferred appointment reminder: Email Text Message Phone[h] Phone[w] Phone[c]

**ADDRESS**

Address:_____

City:_____ State:_____ Zip:_____

**EMPLOYMENT**

Employer:_____ Occupation:_____

**EMERGENCY CONTACT**

Last Name:_____ First Name:_____

Phone number:_____ Relationship to Patient:_____

**FINANCIALLY RESPONSIBLE PARTY (Complete if NOT self/patient is a MINOR/NOT the main policy holder)**

Last Name:_____ First Name:_____

Relationship to patient:_____ Date of Birth_____ SSN:_____

Address:_____ Phone:_____

**PRIMARY PHYSICIAN**

Physician Name:_____ Physician Phone:_____

Physician Address:_____

**PREFERRED PHARMACY**

Pharmacy Name:_____ Address:_____

Phone:_____ Fax:_____

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER

# NOTICE OF PRIVACY PRACTICES

EFFECTIVE: APRIL 14, 2003
REVISED: March 3, 2016

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

## ABOUT THIS NOTICE:

Texas Tech University Health Sciences Center (TTUHSC) is dedicated to maintaining the privacy of your Protected Health Information (PHI). TTUHSC provides health care services and items through its Schools of Medicine, Nursing, Pharmacy and Allied Health Sciences. TTUHSC provides services at its main community hospitals, ambulatory care clinics, ambulatory surgical centers, pharmacies, research units and several community service outreach centers throughout West Texas. TTUHSC is required by law to maintain the privacy of your PHI and provide you with notice of its legal duties and privacy practices. This notice of privacy practices describes how TTUHSC may use or disclose your PHI. PHI includes any information that relates to (1) your past, present, or future physical or mental health or condition; (2) providing health care to you; and (3) the past, present, or future payment for your health care. For TTUHSC at Lubbock, University Medical Center (UMC), and UMC Physicians Network Services (PNS) participate in a clinically integrated health care setting which is considered an organized health care arrangement under HIPAA. This arrangement involves participation of three legally separate entities in the delivery of health care services in which no entity will be responsible for the medical judgment or patient care provided by the other entities in the arrangement. Each entity within this arrangement (TTUHSC, UMC, and PNS) will be able to access and use your PHI to carry out treatment, payment, or health care operations. The terms of this notice shall apply to TTUHSC's privacy practices until it is changed by TTUHSC.

## YOUR PRIVACY RIGHTS:

***When it comes to your health information, you have certain rights.*** This section explains your rights and some of our responsibilities to help you.

- **Get an electronic or paper copy of your medical record**. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, within 14 days of your request. We may charge a reasonable, cost-based fee.
- **Ask us to correct your medical record.** You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- **Request confidential communication.** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- **Ask us to limit what we use and share.** You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- **Get a list of those with whom we've shared information.** You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide accounting once a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Get a copy of this privacy notice.** You can ask for a paper copy of this notice at any time, even if you have agreed to receive this notice electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **File a complaint if you feel your rights are violated.** You may file a complaint in one of the following ways:
  - Contact the TTUHSC privacy official at the address indicated below
  - Use our confidential website at www.Ethicspoint.com
  - Contact The Office for Civil Rights:
    United States Department of Health and Human Services
    1301 Young Street, Suite 1169, Dallas, Texas 75202
    www.hhs.gov/ocr/privacy/hipaa/complaints/

  We will not retaliate or take action against you for filing a complaint.

## YOUR CHOICES:

***For certain health information, you can tell us your choices about what we share.*** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- **In these cases, you have both the right and choice to tell us to:**
  - Share information with your family, close friends, or others involved in your care.
  - Share information in a disaster relief situation.
  - Include your information in a hospital directory
  - If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- **In these cases we never share your information unless you give us written permission:**
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes

**TTUHSC USES AND DISCLOSURES:**

***How do we typically use or share your health information?*** The following uses do **NOT** require your authorization, except where required by Texas Law.

- **Treat you**. We can use your health information and share it with other professionals who are treating you. For example: a doctor treating you for an injury asks another doctor about your overall health condition.
- **Run our organization.** We can use and share your health information to run our practice, improve your care, and contact you when necessary. For example, we use health information about you to manage your treatment and services.
- **Bill for your services**. We can use and share your health information to bill and get payment from health plans or other entities. For example, we give information about you to your health insurance plan so it will pay for your services.
- **In the case of fundraising.** We may use your PHI to contact you for fundraising efforts. We must include in any fundraising material you receive a description of how you may opt out of receiving future fundraising communications.
- **How else can we use or share your health information?** We are allowed or required to share your information in other ways-usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html
    - **Help with public health and safety issues.**
        - We can share health information about you for certain situations such as:
            - Preventing disease
            - Helping with product recalls
            - Reporting adverse reactions to medications
            - Reporting suspected abuse, neglect, or domestic violence
            - Preventing or reducing a serious threat to anyone's health or safety
    - **Conducting Research**. We can use or share your information for health research.
    - **Comply with the law.** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
    - **Respond to organ and tissue donation requests**. We can share health information about you with organ procurement organizations.
    - **Work with a medical examiner or funeral director.** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
    - **Address workers' compensation, law enforcement, and other government request.**
        - We can use or share health information about you:
            - For workers' compensation claims
            - For law enforcement purposes or with a law enforcement official
            - With health oversight agencies for activities authorized by law
            - For special government functions such as military, national security, and presidential protective services
    - **Respond to lawsuits and legal actions.** We can use or share health information about you in response to a court or administrative order, or in response to a subpoena.

**TTUHSC RESPONSIBILITIES:**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

**CHANGE IN NOTICE OF PRIVACY PRACTICES:**

TTUHSC reserves the right to change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

**QUESTIONS:**

If you have any questions about this notice or would like additional information, please contact the privacy official at the address and telephone number listed below or you may visit our web site at www.ttuhsc.edu/hipaa

**PRIVACY OFFICIAL CONTACT INFORMATION**

| | | |
|---|---|---|
| REGIONAL PRIVACY OFFICER<br>AT AMARILLO<br>1400 COULTER ROAD<br>AMARILLO, TX 79106<br>(806) 414-9607 | REGIONAL PRIVACY OFFICER<br>AT LUBBOCK<br>3601 4TH STREET, STOP 8165<br>LUBBOCK, TX 79430<br>(806) 743-9541 | REGIONAL PRIVACY OFFICER<br>AT THE PERMIAN BASIN<br>800 WEST 4TH STREET<br>ODESSA, TX 79763<br>(806) 743-9539 |

www.Ethicspoint.com

TTUHSC Provides For Program Accessibility To Members Of The Public. Those Who Need Materials In Braille, Large Print, Tape Format, Or Who Need An Interpreter Or Telecommunications Device For The Deaf Are Asked To Contact The Clinic Manager.

# Texas Tech University
# Health Sciences Center

## Acknowledgement of Notice of Privacy Practice and Confirmation of Various Healthcare Communications

☐ I have received a copy of the Texas Tech University Health Sciences Center (TTUHSC) Notice of Privacy Practices (rev. 3/16) in **accordance with 45 CFR § 164.520.**

***Consent to Email or Text Usage for Appointment Reminders and other Healthcare Communications:***

☐ I consent to receive email and/or text messaging from TTUHSC to remind me of an appointment, for surveys about my experience with the healthcare team, or to provide general health reminders or information about new services.

The cell phone number and/or email I authorize for TTUHSC to use are listed below:

**Email:** _____

**Cell phone number:** _____

*TTUHSC does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan.*

By signing below, I acknowledge any options selected above, will remain in effect until further written notification by me.

| Date | Print Your Name<br>(Person signing consent form) | Signature<br>(Patient or Other Legally Authorized Person) | |
|---|---|---|---|
| | | Relationship to Patient | |

# Texas Tech University Health Sciences Center Ambulatory Clinics

## Consent to Treatment/Health Care Agreement

**CONSENT TO TREATMENT**: I voluntarily consent to receive medical and health care services provided by Texas Tech University Health Sciences Center physicians, employees and such associates, assistants, and other health services may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment, identification and payment purposes only. I understand that TTUHSC is a teaching institution. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I understand that this Consent to Treatment/Health Care Agreement will be valid and remain in effect as long as I attend or receive services from the TTUHSC Ambulatory Clinics, unless revoked by me in writing with such written notice provided to each clinic I attend or from which I receive services.

**RELEASE OF MEDICAL INFORMATION:** I understand that my prescriptions and prescription history will be sent, received and shared electronically with other healthcare providers and pharmacies. In addition, my medical records are available to other healthcare providers for treatment purposes through Health Information Exchanges (HIE). An HIE is an electronic system that stores your health information from multiple sources, not just TTUHSC, and may contain mental health and substance abuse information. Providers will attempt to exclude certain mental health and substance abuse records, but some portions of this information may be included. I may opt out of the HIE by completing an Opt-Out form. If I later change my mind, I may opt back in the same way.

**FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:** In consideration for receiving medical or health care services, I hereby assign to TTUHSC physicians and providers and/or the TTUHSC Medical Practice Income Plan my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to TTUHSC physicians and/or Medical Practice Income Plan. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct. **I agree to pay all charges for medical and health care services not covered by, or which exceed, the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer, and agree to make payment as requested by TTUHSC.**

**ADVANCE DIRECTIVE:**

Do you have a current, signed Advance Directive? ☐ YES ☐ NO

Has a signed copy been provided to TTUHSC? ☐ YES ☐ NO

***By signing below, I agree I have read this form or it has been read to me and I understand what it is saying and agree to the terms.***

| Date | Print Name | Signature Patient/ legally authorized person |
|---|---|---|

| Witness/Translator | Relationship to Patient |
|---|---|

# Texas Tech University Health Sciences Center

## Confidential Communication Request

Patient Name: _____

MRN: _____

DOB: _____

TTUHSC values the privacy of its patients and is committed to operating our practice in a manner that promotes patient confidentiality while providing high quality patient care. TTUHSC will accommodate reasonable requests.

If you need copies of medical records, you will need to complete a different authorization form. Please ask a staff member for the required form.

☐ Permission to give verbal protected health information (including appointment information) and leave messages with the following person(s): Example: family members, friends, personal caregivers, etc. You do not need to list any medical providers who are involved in your care. The patient and individuals listed below must provide at least one of the following: patient's address, patient's date of birth, last four digits of the patient's Social Security number.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

**Please note that TTUHSC cannot leave specific test results or details of treatment plan on answering machines or voice mail due to our concern for your privacy.**

Please complete the following questions for additional level of security which staff may ask if they have concerns on releasing your information. **Please provide at least one answer.**

1. What was your mother's maiden name? _____
2. What town were you born in? _____
3. What is your grandmother's name? _____
4. What is the name of your first pet? _____

**Date**

**Print Your Name and Relationship to Patient (Person signing consent form)**

**Signature (Patient or Other Legally Authorized Person)**

**Relationship to Patient**

**TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER**

**Informed Consent to Telemedicine/Telephone/Telepharmacy/Teletherapy Consultation**

You are scheduled for a telemedicine/telephone/telepharmacy/teletherapy consultation. Prior to your visit, is important that you read and understand this document.

By signing this document, you are attesting that you understand:

1. The purpose is to assess and treat your medical condition.
2. This consult is done through a two-way communication whereby the physician or other health provider at TTUHSC can see your image on the screen and/or hear my voice. However, unlike a traditional medical consult, the physician or other health provider does not have the use of the other senses such as touch or smell; and it may not be equal to a face-to-face visit.
3. Since we are in different locations, we must rely on information provided by you. TTUHSC and affiliated telemedicine/telephone/telepharmacy/teletherapy consultants rely on your accurate and complete information to provide appropriate care.
4. You can ask questions and seek clarification of the procedures and telemedicine technology.
5. You can ask that the telemedicine exam and/or videoconference be stopped at any time.
6. You know there are potential risks with the use of this new technology. These include but are not limited to:
    - Interruption of the audio/video link.
    - Disconnection of the audio/video link
    - A picture that is not clear enough to meet the needs of the consultation
    - Electronic tampering.

    If any of these risks occur, the procedure might need to be stopped.
7. The consultation may be viewed, heard or videotaped by medical and non-medical persons for evaluation, informational, research, educational, quality, technical purposes, or as might be required by my health coverage plan.
8. You understand you can make a complaint of your provider to the appropriate licensing board.

If you have any questions or concerns about this document, please make sure to ask your nurse or healthcare provider.

Printed Name: _____

Signature: _____
(Patient/Parent/Guardian)

Date: _____

## Texas Tech University Health Sciences Center
## Consent and Release to Use Image or Information

I, (print name) _____
or my authorized legal representative, hereby give consent for Texas Tech University Health Sciences Center (TTUHSC) employees, students or agents to take and use information about me (including my medical history, if applicable), my name or image or likeness including, but not limited to, photographs, videotaped images, audio recordings, digital (collectively "Images"), or my data or presentation for the purposes checked below.

| **I AGREE TO USES DESIGNATED BELOW:** ***(Not including uses for patient treatment or payment.)*** | My Name | My Image(s) | My Information | My Data or Presentation |
|---|---|---|---|---|
| ☑ For educational purposes **within** TTUHSC. | ☑ Yes ☐ No | ☑ Yes ☐ No | ☑ Yes ☐ No | ☑ Yes ☐ No |
| ~~☐ For educational purposes **outside** TTUHSC.~~ | ~~☐ Yes ☐ No~~ | ~~☐ Yes ☐ No~~ | ~~☐ Yes ☐ No~~ | ~~☐ Yes ☐ No~~ |
| ~~☐ For TTUHSC marketing or publicity. (This includes news and social media such as interviews, Facebook, websites, Twitter, YouTube, etc.)~~ | ~~☐ Yes ☐ No~~ | ~~☐ Yes ☐ No~~ | ~~☐ Yes ☐ No~~ | ~~☐ Yes ☐ No~~ |
| ~~☐ For publication in journals or on the Internet~~ | ~~☐ Yes ☐ No~~ | ~~☐ Yes ☐ No~~ | ~~☐ Yes ☐ No~~ | ~~☐ Yes ☐ No~~ |
| ~~☐ Other purpose(s):~~ | ~~☐ Yes ☐ No~~ | ~~☐ Yes ☐ No~~ | ~~☐ Yes ☐ No~~ | ~~☐ Yes ☐ No~~ |

**I understand that TTUHSC and its regents, employees, agents, and personnel, acting on behalf of TTUHSC, shall not be held responsible for any use of my name, information and/or image(s), including any use whatsoever by any outside user or third parties, and I hereby release and hold harmless TTUHSC and its regents, employees, agents and personnel, acting on its behalf, from any and all liability for damages of whatever kind, character or nature which may at any time result from this Consent and Release authorizing use or dissemination in accordance with the above.**

I understand that TTUHSC will own the Image(s) of me for the purposes stated above. I do hereby knowingly and voluntarily waive any and all other rights, compensation, royalties, or payment of any kind or character in connection with the use of my name, likeness and/or image(s) as authorized above.

This Consent and Release can be revoked or withdrawn at any time, but such withdrawal or revocation must be in writing and sent to the TTUHSC Institutional Privacy Officer. Any withdrawal of consent does not affect any information used or disclosed prior to receipt of the written notice of withdrawal.

By signing below, I represent that I have read and understand this "Consent and Release to Use Image or Information" and that it is binding on my heirs, executors and personal representatives. I am 18 years of age or older.

_____ _____
**Signature of Person Named Above** Date

_____ _____
**OR Signature and Print Name of Authorized Legal Representative** Date

| *For Office Use Only:* | Completed by: _____ | |
|---|---|---|
| Date of Event: _____ ☐ Speaker | MR#: _____ ☐ Patient | R# (Banner): _____ ☐ Faculty ☐ Staff ☐ Student |

Texas Tech University

Health Sciences Center

School of Medicine

**This questionnaire helps us gather information about your child and family that will be helpful in determining the type of treatment which would most likely help the problems your child is expecting. Please fill out all of the questions completely as possible.**

## I. Identifying Information

Child's Name: _____
Last First Middle

Address: _____
Street City State Zip

Date of Birth ____/____/____ Current age ____ **Ethnicity**: White Hispanic Afr. Amer. Asian Other

Grade: _____ School _____ District: _____

Legal Guardian Bringing Child for Treatment _____Relationship to child _____

## II. Parents (if parents are separated, please circle parent child lives with most of the time)

Mother: _____Hm Phone:_____Wrk Phone:_____
Father: _____ Hm Phone: _____ Wrk Phone:_____

## III. Marital History

| | Date of marriage | Date of Divorce/Widowed (If applicable) | Name of Step-Parent |
|---|---|---|---|
| Child's Bio/Adoptive Parent | _____ | _____ | _____ |
| Mother's 2nd Marriage | _____ | _____ | _____ |
| Father's 2nd Marriage | _____ | _____ | _____ |
| Mother's 3rd Marriage | _____ | _____ | _____ |
| Father's 3rd Marriage | _____ | _____ | _____ |

If parents are separated, does the non-custodial parent want to be involved in the treatment of the child? ☐Y ☐N

If YES: do you think the non-custodial parent will object to medication or counseling for your child? ☐Y ☐N

| Mom/step-mother's educational level: | Father/step-father's educational level: |
|---|---|
| ☐ 1. Less than 7th grade | ☐ 1. Less than 7th grade |
| ☐ 2. 8-9th grade | ☐ 2. 8-9th grade |
| ☐ 3. 10-11th grade | ☐ 3. 10-11th grade |
| ☐ 4. High school graduate | ☐ 4. High school graduate |
| ☐ 5. Partial college (at least 1 yr.) | ☐ 5. Partial college (at least 1 yr.) |
| ☐ 6. Standard college degree (i.e. 4 yrs.) | ☐ 6. Standard college degree (i.e. 4 yrs.) |
| ☐ 7. Graduate degree beyond college | ☐ 7. Graduate degree beyond college |
| Current occupation: _____ | Current occupation: _____ |

## IV. Brothers and sisters or other family members in child's main residence

1. _____ Age (  )
2. _____ Age (  )
3. _____ Age (  )
4. _____ Age (  )
5. _____ Age (  )
6. _____ Age (  )
7. _____ Age (  )

## V. Child's problems

Please briefly describe your child's problems: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

## VI. Child's Health History

### A. Mental Health Treatment

**Please list any medications your child is on now or has been on in the past for behavioral/emotional problems:**

| Medicine | Doctor | Dates taken | Results |
|---|---|---|---|
| _____ | | | Good Fair Poor |
| _____ | | | Good Fair Poor |
| _____ | | | Good Fair Poor |
| _____ | | | Good Fair Poor |

Has your child been in therapy or counseling before? ☐ Yes ☐ No

| Therapist/clinic | When | No. of Times seen | Results |
|---|---|---|---|
| _____ | | | Good Fair Poor |
| _____ | | | Good Fair Poor |
| _____ | | | Good Fair Poor |

Has your child been in a psychiatric (mental) hospital before? ☐ Yes ☐ No

| Hospital | When | Doctor | Results |
|---|---|---|---|
| _____ | | | Good Fair Poor |
| _____ | | | Good Fair Poor |
| _____ | | | Good Fair Poor |

### B. Medical History

**Please list any serious illness, operations, or hospitalizations:**

| Child's age When ill | Type of illness/injury | Treatment |
|---|---|---|
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |

**C. Did you have any difficulties during your pregnancy or during child birth? If yes, please describe:**

_____

_____

_____

## VII. Development

At what age did your child:

Hold his/her heap up _____ Smile _____ Sit up_____

Take first steps _____ Walk _____ Run _____

Babble, coo _____ Say first words _____ Use sentences _____

Toilet trained _____ Was toilet training easy/hard? _____

Did he/she suffer from colic? If yes, please describe: _____

_____

As an infant or toddler did your child have trouble attaching or bonding to either parent? If yes, please describe: _____

_____

Did he/she have or had any speech delays or problems? _____

_____

_____

Does he/she have problems with poor motor coordination (being clumsy?) _____

If yes, please describe: _____

_____

| | | |
|---|---|---|
| Does your child have a main best friend? | Yes ☐ | No ☐ |
| Does your child have a steady group of friends? | Yes ☐ | No ☐ |
| Does your child have trouble making friends? | Yes ☐ | No ☐ |
| Does he/she have trouble keeping friends? | Yes ☐ | No ☐ |
| Does he/she have friends who get him/her in trouble? | Yes ☐ | No ☐ |

Is he/she a leader or a follower? _____

| | | |
|---|---|---|
| Do neighbors tell their child not to interact with your child? | Yes ☐ | No ☐ |
| Do other children think your child is “weird” or “odd”? | Yes ☐ | No ☐ |
| Do other children think your child is mean? | Yes ☐ | No ☐ |
| Does he/she play mostly with younger children? | Yes ☐ | No ☐ |

Do teachers/day care workers say your child doesn’t get along with other children? Yes ☐ No ☐

## VIII. Child's Schooling

Please list the schools your child has attended since Kindergarten:

| Grade | School | Teacher reported behavior or learning problems? | In Special Education? |
|---|---|---|---|
| K | _____ | Yes No | Yes No |
| 1st | _____ | Yes No | Yes No |
| 2nd | _____ | Yes No | Yes No |
| 3rd | _____ | Yes No | Yes No |
| 4th | _____ | Yes No | Yes No |
| 5th | _____ | Yes No | Yes No |
| 6th | _____ | Yes No | Yes No |
| 7th | _____ | Yes No | Yes No |
| 8th | _____ | Yes No | Yes No |
| 9th | _____ | Yes No | Yes No |
| 10th | _____ | Yes No | Yes No |
| 11th | _____ | Yes No | Yes No |
| 12th | _____ | Yes No | Yes No |

## IX. Child's Activities

Bedtime on School Days: _____ Weekends/holidays: _____ Sleeps by self? _____

Typical bedtime behavior: ☐ Goes to bed easily ☐ Argues/resists ☐ Scared/needs reassurance

Wets bed? Yes No Nightmares? Yes No Sleepwalking? Yes No Loud snoring? Yes No

Wake up time school days: _____ Wake up time weekends: _____ Hours sleep/night: _____

Avg. hour's television watched on school nights: _____ Weekend: _____

What sports is child involved in? _____

_____

_____

What other structured activities (scouts, church, etc.) is the child involved in? _____

_____

_____

Describe child's computer/internet usage: _____

_____

_____

Each rating should be based on what is appropriate for the age of your child. Please rate child's behaviors observed in the past 6 months, using these frequency codes:

0= **Never** 1=**Occasionally** 2=**Often** 3= **Very Often**

| | | | | | |
|---|---|---|---|---|---|
| 1. | Does not pay attention to details or makes careless mistakes with (i.e.) homework. | 0 | 1 | 2 | 3 |
| 2. | Has difficulty sustaining attention to tasks/activities. | 0 | 1 | 2 | 3 |
| 3. | Does not seem to listen when spoke to directly. | 0 | 1 | 2 | 3 |
| 4. | Does not follow through when given directions and fails to finish activities (not due to oppositional behavior or failure to understand). | 0 | 1 | 2 | 3 |
| 5. | Has difficulty organizing tasks and activities. | 0 | 1 | 2 | 3 |
| 6. | Avoids, dislikes, or is reluctant to start tasks that require continuous mental effort. | 0 | 1 | 2 | 3 |
| 7. | Loses things necessary for tasks or activities (toys, assignments, pencils, books). | 0 | 1 | 2 | 3 |
| 8. | Is easily distracted by noises or other stimuli around him/her. | 0 | 1 | 2 | 3 |
| 9. | Is forgetful in daily activities. | 0 | 1 | 2 | 3 |
| 10. | Fidgets with hands or feet or squirms in seat. | 0 | 1 | 2 | 3 |
| 11. | Leaves seat when remaining seated is expected. | 0 | 1 | 2 | 3 |
| 12. | Runs or climbs too much when remaining seated is expected. | 0 | 1 | 2 | 3 |
| 13. | Has difficulty playing quietly. | 0 | 1 | 2 | 3 |
| 14. | Is "on the go" or acts as if "driven by a motor". | 0 | 1 | 2 | 3 |
| 15. | Talks too much. | 0 | 1 | 2 | 3 |
| 16. | Blurts out answers before the questions have been completed/ | 0 | 1 | 2 | 3 |
| 17. | Has difficulty waiting his or her turn. | 0 | 1 | 2 | 3 |
| 18. | Interrupts/intrudes on others (i.e. butts into conversations or games). | 0 | 1 | 2 | 3 |
| 19. | Argues with adults. | 0 | 1 | 2 | 3 |
| 20. | Loses temper. | 0 | 1 | 2 | 3 |
| 21. | Actively defies/refuses to go along with adults' request or rules. | 0 | 1 | 2 | 3 |
| 22. | Deliberately annoys people. | 0 | 1 | 2 | 3 |
| 23. | Blames other for his/her mistakes/misbehaviors. | 0 | 1 | 2 | 3 |
| 24. | Is touchy or easily annoyed by others. | 0 | 1 | 2 | 3 |
| 25. | Is angry or resentful. | 0 | 1 | 2 | 3 |
| 26. | Is spiteful and vindictive (i.e. wants to get even). | 0 | 1 | 2 | 3 |
| 27. | Bullies, threatens, or intimidates others. | 0 | 1 | 2 | 3 |
| 28. | Starts physical fights. | 0 | 1 | 2 | 3 |
| 29. | Lies to obtain goods or to avoid obligations (i.e. "cons" others). | 0 | 1 | 2 | 3 |
| 30. | Is truant from school (skips school) without permission. | 0 | 1 | 2 | 3 |

| | | | | | |
|---|---|---|---|---|---|
| 31. | Is physically cruel to people. | 0 | 1 | 2 | 3 |
| 32. | Has stolen things that have value. | 0 | 1 | 2 | 3 |
| 33. | Deliberately destroys others' property. | 0 | 1 | 2 | 3 |
| 34. | Used a weapon that can cause serious harm (bat,knife,brick,gun). | 0 | 1 | 2 | 3 |
| 35. | Is physically cruel to animals. | 0 | 1 | 2 | 3 |
| 36. | Has deliberately set fires to cause damage. | 0 | 1 | 2 | 3 |
| 37. | Has broken into someone else's home, business, or car. | 0 | 1 | 2 | 3 |
| 38. | Has stayed out at night without permission. | 0 | 1 | 2 | 3 |
| 39. | Has run away from home. | 0 | 1 | 2 | 3 |
| 40. | Has forced someone into sexual activity. | 0 | 1 | 2 | 3 |
| 41. | Is fearful, anxious, or worried. | 0 | 1 | 2 | 3 |
| 42. | Is afraid to try new things for fear of making mistakes. | 0 | 1 | 2 | 3 |
| 43. | Feels worthless or inferior. | 0 | 1 | 2 | 3 |
| 44. | Blames self for problems, feels guilty. | 0 | 1 | 2 | 3 |
| 45. | Feels lonely, unwanted or unloved: sys that "no one loves" him/her. | 0 | 1 | 2 | 3 |
| 46. | Is sad, unhappy, or depressed. | 0 | 1 | 2 | 3 |
| 47. | Is self-conscious or easily embarrassed. | 0 | 1 | 2 | 3 |

Below is a list of statements that describe how people feel. Read each phrase and decide if it is "not true or hardly ever true", or "somewhat true or sometimes true" or "very true or often true" for your child. Then for each sentence, circle the number that corresponds to the response that seems to describe your child for the last 3 months.

| | | Not true; hardly ever true | Somewhat true: sometimes true | Very true; often true |
|---|---|---|---|---|
| 1. | My child gets really frightened for no reason at all. | 0 | 1 | 2 |
| 2. | My child is afraid to be alone in the house. | 0 | 1 | 2 |
| 3. | People tell me that my child worried too much. | 0 | 1 | 2 |
| 4. | My child is scared to go to school. | 0 | 1 | 2 |
| 5. | My child is shy. | 0 | 1 | 2 |

This form is about how your child might have been feeling or acting recently.
For each question, please check how much he or she has felt or acted this way in the past 2 weeks.
If a sentence was true most of the time, circle 2= TRUE. If it was only sometimes true, circle 1= SOMETIMES. If a sentence was not true, circle 0= NOT TRUE.

| | | NOT TRUE | SOME-TIMES | TRUE |
|---|---|---|---|---|
| 1 | He/she felt miserable or unhappy. | 0 | 1 | 2 |
| 2 | He/she didn't enjoy anything at all. | 0 | 1 | 2 |
| 3 | He/she was less hungry than usual. | 0 | 1 | 2 |
| 4 | He/she ate more than usual. | 0 | 1 | 2 |
| 5 | He/she felt so tired he/she sat around and did nothing. | 0 | 1 | 2 |
| 6 | He/she was moving and walking more slowly than usual. | 0 | 1 | 2 |
| 7 | He/she was very restless. | 0 | 1 | 2 |
| 8 | He/she felt he/she was no good no more. | 0 | 1 | 2 |
| 9 | He/she blamed himself/her for things that weren't his/her fault. | 0 | 1 | 2 |
| 10 | It was hard for him/her to make up his/her mind. | 0 | 1 | 2 |
| 11 | He/she felt grumpy and cross with you. | 0 | 1 | 2 |
| 12 | He/she felt like talking less than usual. | 0 | 1 | 2 |
| 13 | He/she was talking more slowly than usual. | 0 | 1 | 2 |
| 14 | He/she cried a lot. | 0 | 1 | 2 |
| 15 | He/she thought there was nothing good for him/her in the future. | 0 | 1 | 2 |
| 17 | He/she thought life wasn't worth living. | 0 | 1 | 2 |
| 18 | He/she thought about death or lying. | 0 | 1 | 2 |
| 19 | He/she thought his/her family would be better off without him/her. | 0 | 1 | 2 |
| 20 | He/she thought about killing himself/her. | 0 | 1 | 2 |
| 21 | He/she found it hard to think properly or concentrate. | 0 | 1 | 2 |
| 22 | He/she thought bad things would happen to him/her. | 0 | 1 | 2 |
| 23 | He/she hated himself/her. | 0 | 1 | 2 |
| 24 | He/she felt he/she was a bad person. | 0 | 1 | 2 |
| 25 | He/she thought he/she looked ugly. | 0 | 1 | 2 |
| 26 | He/she worried about aches and pains. | 0 | 1 | 2 |
| 27 | He/she felt lonely. | 0 | 1 | 2 |
| 28 | He/she thought nobody really loved him/her. | 0 | 1 | 2 |
| 29 | He/she didn't have any fun at school. | 0 | 1 | 2 |
| 30 | He/she thought he/she could never be as good as other kids. | 0 | 1 | 2 |
| 31 | He/she felt he/she did everything wrong. | 0 | 1 | 2 |
| 32 | He/she didn't sleep as well as he/she usually sleeps. | 0 | 1 | 2 |
| 33 | He/she slept a lot more than usual. | 0 | 1 | 2 |
| 34 | He/she wasn't as happy as usual, even when praised or rewarded him/her. | 0 | 1 | 2 |

The following questions concern your child's mood and behavior in the **past month**. Please place a check mark or an 'X' in a box for each item. Please consider it a problem if it is **causing trouble** and is beyond what is normal for your child's age. Otherwise, check 'rare or never' if the behavior is not causing trouble.

| | Does your child… | Never rarely | Some times | Often | Very often |
|---|---|---|---|---|---|
| 1 | Have periods of feeling super happy for hours or days at a time, extremely wound up and excited, such as feeling "on top of the world" | 0 | 1 | 2 | 3 |
| 2 | Feel irritable, cranky, or mad for hours or days at a time. | 0 | 1 | 2 | 3 |
| 3 | Think that he/she can be anything or do anything (i.e., leader, best basketball player, rap singer, millionaire, princess) beyond what is usual for that age | 0 | 1 | 2 | 3 |
| 4 | Believe that he/she has unrealistic abilities, or powers that are unusual, and may try to act upon them, which causes trouble | 0 | 1 | 2 | 3 |
| 5 | Need less sleep than usual: yet does not feel tired the next day | 0 | 1 | 2 | 3 |
| 6 | Have periods of too much energy | 0 | 1 | 2 | 3 |
| 7 | Have periods when he/she talks too much or too loud or talks a mile minute | 0 | 1 | 2 | 3 |
| 8 | Have periods of racing thoughts that his/her mind cannot slow down, and it seems that your child's mouth cannot keep up with his/her mid | 0 | 1 | 2 | 3 |
| 9 | Talk so fast that he/she jumps from topic to topic | 0 | 1 | 2 | 3 |
| 10 | Rush around doing things nonstop | 0 | 1 | 2 | 3 |
| 11 | Have trouble staying on track and is easily drawn to what is happening around him/her | 0 | 1 | 2 | 3 |
| 12 | Do may more things than usual, or is unusually productive or highly creative | 0 | 1 | 2 | 3 |
| 13 | Behave in a sexually inappropriate was (i.e., talks dirty, exposing, playing with private parts, masturbating, making sex phone calls, humping on dogs, playing sex games, touches others sexually) | 0 | 1 | 2 | 3 |
| 14 | Go and talk to strangers inappropriately, is more socially outgoing than usual | 0 | 1 | 2 | 3 |
| 15 | Do things that are unusual for him/her that are foolish or risky (i.e., jumping off heights, ordering CDs with your credit cards, giving things away) | 0 | 1 | 2 | 3 |
| 16 | Have rage attacks, intense and prolonged temper tantrums | 0 | 1 | 2 | 3 |
| 17 | Cracks jokes more than usual, laugh loud or act silly in a way that is out of the ordinary | 0 | 1 | 2 | 3 |
| 18 | Experience rapid mood swings | 0 | 1 | 2 | 3 |
| 19 | Have suspicious or strange thoughts | 0 | 1 | 2 | 3 |
| 20 | Hear voices that nobody else can hear | 0 | 1 | 2 | 3 |
| 21 | See things that nobody else can see | 0 | 1 | 2 | 3 |

# Traumatic Events

In this form, we ask questions about things that sometimes happen to kids and teenagers. Some of these things may have been upsetting or scary to your child. If the event has never occurred to your child, please mark the box under the word "No". If the event has occurred but was not upsetting or scary to your child, please mark the box under the word "Yes". If the event occurred and was scary/upsetting to your child, please mark the box under that choice. Please think carefully about each question. We may talk to you further about your answers. Please mark the appropriate box for each question.

| | | YES | NO | Yes;was upsetting or scary |
|---|---|---|---|---|
| 1 | Has your child ever been in a really bad accident? i.e. car accident, fall or a fire? | ☐ | ☐ | ☐ |
| 2 | Has your child ever witnessed a really bad accident that he/she was not in? | ☐ | ☐ | ☐ |
| 3 | Has your child ever been in a really bad storm, like a tornado, hurricane, or a blizzard? Or a flood, or earthquake? Or was your child ever been struck by lightning? | ☐ | ☐ | ☐ |
| 4 | Has your child ever known someone who got really hurt or sick or even died? | ☐ | ☐ | ☐ |
| 5 | Has someone ever attacked your child or tried to hurt your child really bad on purpose? | ☐ | ☐ | ☐ |
| 6 | Has someone ever told your child that they were going to hurt him/her really badly, or acted like they were going to hurt him/her badly? | ☐ | ☐ | ☐ |
| 7 | Has someone a lot older tried to rob or steal from your child?..Or mug your child? | ☐ | ☐ | ☐ |
| 8 | Has someone ever kidnapped your child or taken your child away when they weren't supposed to? | ☐ | ☐ | ☐ |
| 9 | Has your child ever seen people not in your family fighting/attacking each other? Or shooting with a gun? Or stabbing with a knife? Or beating each other up? | ☐ | ☐ | ☐ |
| 10 | Even if they were weren't physically attacking each other, has your child ever heard people in your family yelling and screaming at each other a lot? | ☐ | ☐ | ☐ |
| 11 | Has someone ever touched your child's body's private parts in a way that your child didn't want or that made your child feel uncomfortable? Or made your child touch their body's private parts? Or made your child do something sexual that your child didn't want to do? | ☐ | ☐ | ☐ |
| 12 | Has anyone ever physically hurt or injured your child really badly on purpose? | ☐ | ☐ | ☐ |
| 13 | Has there been some other time when something happened that really made your child feel scared or upset, or that bothers your child a lot now? What happened? | ☐ | ☐ | ☐ |

If you said yes to any of the above events:

Do you worry your child's current problems are related to the traumatic events? ☐ YES ☐ NO

Does your child ever seem like he/she is re-living the trauma? ☐ YES ☐ NO

Does he/she have lots of nightmares about the trauma? ☐ YES ☐ NO

Does he/she have flashbacks about the trauma? ☐ YES ☐ NO

## Family History

If your family members have history of mental illness, or have mental illness at present, please write the **"X"** sign in the box under the group that it applies to (mother, father, sibling or others). If you are not sure but suspect that they have mental illness, please write a question mark **"?"** in the appropriate box. If family members don't have mental illness, please leave the boxes **empty.**

| Disorder: | Mother | Father | Siblings | Others | Comment |
|---|---|---|---|---|---|
| 1) ADHD | | | | | |
| 2) Learning Disability | | | | | |
| 3) Mental Retardation | | | | | |
| 4) Psychosis/ Schizophrenia | | | | | |
| 5)Manic depressive/bipolar disorder | | | | | |
| 6) Major depressive disorder | | | | | |
| 7) Suicide | | | | | |
| 8) Anxiety Disorder | | | | | |
| 9) Tics/Tourette syndrome | | | | | |
| 10) Alcohol Abuse | | | | | |
| 11) Substance Abuse | | | | | |
| 12) Inpatient psychiatric hospitalization | | | | | |
| 13)Epilepsy/Seizures | | | | | |
| 14) Other mental problems: | | | | | |

**Name of person filling out form** **Relationship to child** **Signature** **Date**

**Reviewed by clinician:** _____ Date: ____/____/_____

# Treatment Goals Checklist

**This information is being collected under the authority of the Health and Social Service Authority in order to provide services. It is protected by the privacy provisions of the Access to information and Protection of Privacy (ATIPP). If you have questions about the collection or use of the information, please contact the manager/supervisor at the program providing the service. (The receptionist can direct you to the manager or supervisor)**

Client Name: _____ Date: _____

The following is a list of goals that people coming to treatment sometimes have. Please indicate what your present goals are by circling yes and which are not your present goals by circling no.

| | |
|---|---|
| 1. To deal with my problem of alcohol and/or drug use and/or gambling. | ☐ Yes ☐ No |
| 2. To learn to manage stress appropriately. | ☐ Yes ☐ No |
| 3. To learn to stand up for myself better. | ☐ Yes ☐ No |
| 4. To be able to deal with my feelings and express them directly. | ☐ Yes ☐ No |
| 5. To improve my relationship with members of my family (spouse, children, parents, etc.). | ☐ Yes ☐ No |
| 6. To be able to get along better socially. | ☐ Yes ☐ No |
| 7. To improve my ability to find and keep a job. | ☐ Yes ☐ No |
| 8. To learn to use my leisure time better. | ☐ Yes ☐ No |
| 9. To improve my living arrangements. | ☐ Yes ☐ No |
| 10. To deal effectively with my financial problems. | ☐ Yes ☐ No |
| 11. To deal effectively with my legal problems. | ☐ Yes ☐ No |
| 12. To deal effectively with my medical problems. | ☐ Yes ☐ No |
| 13. To manage my emotional/mental health issues appropriately. | ☐ Yes ☐ No |
| 14. Other-Please specify _____ | ☐ Yes ☐ No |

**Summary**

How many goals have you indicated? _____

Of the goals you indicated, which are the most important for you to solve at the moment?

My first most important goal is # _____

My second most important goal is # _____

My third most important goal is # _____