HMC
HIGHLAND MEDICAL CENTER
Caring for the health of the Highlands

Patient Name: _____ DOB: _____

Limitations on Confidential Nature of Communications

Communications between a licensed psychologist, psychiatrist, licensed clinical social worker, or licensed professional counselor and the patient are confidential and will not be released without the expressed authorization of the patient. However, certain communication may occur where confidentiality is limited. They are as follows:

- Should a provider believe the patient is a threat to others or themselves
- When records are ordered to be released by a Judge or Court
- When information involves child abuse or abuse of the elderly
- When information is given about the transmission of contagious or transmittable diseases
- Should the patient's account be turned over to an attorney/collection agency for non-payment
- When you are determined incapacitated by your health care provider information may be given to your guardian or medical power of attorney

I acknowledge that I understand and agree to the above payment policy and limitations of confidentiality.

_____ _____
Patient/Parent/ Responsible Party Date

_____ _____
Staff Date

Consent to Treat

I understand that as in all types of medical and psychological treatment, there are certain risks. This includes the general risk that there may be emotional pain, stress, and/or life changes associated with mental health treatment helps many individuals, it is not always completely effective. I hereby give written consent for mental health treatment. My clinician will inform me of other specific treatment risks that may be involved in my case, and/or I will ask any questions I may have about specific treatment risks.

_____ _____
Patient/Parent/ Responsible Party Date

Understanding Health Information Privacy

The HIPAA Privacy Rule provides federal protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of health information needed for patient care and other important purposes. HMC can receive and share health information with other health professionals and hospitals who are treating you.

The Security Rule specifies a series of administrative, physical, and technical safeguards for covered entities and their business associates to use to assure the confidentiality, integrity, and availability of electronic protected health information.

By completing below, I am acknowledging that I have read the Highland Medical Center's Privacy Notice, have been offered a copy, and had an opportunity to ask question.

Printed Name of Patient: _____

Date of Birth of Patient: _____

Printed Name of Guardian, if appropriate: _____

Signature of Patient or Guardian: _____Date: _____

RELEASE OF INFORMATION

Often it is difficult to reach a patient to convey physician orders or test results. In this event, with your signed authorization, we would release such information to a person you designate. Please complete the section below.

I authorize Highland Medical Center, Inc. to release any information required in the course of my examination or treatment to the following designated person(s):

PLEASE CIRCLE WHICH ONE IS YOUR EMERGENCY CONTACT

Name: _____ Relationship & Phone #: _____

Name: _____ Relationship & Phone #: _____

Name: _____ Relationship & Phone #: _____

ADVANCE DIRECTIVE (Living Will/ Medical Power of Attorney)

An Advance Directive is a legal document that states your wishes regarding medical treatment in the event that you are unable to communicate these decisions. *It is very important that all of your healthcare providers have a current copy of these documents.*

____ I HAVE completed an Advance Directive.
Copy provided to HMC? Yes / No

____ I HAVE NOT completed an Advance Directive.
I would like more information. Yes / No

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Behavioral Health – Pediatric Psychosocial

Identifying Information **Date:** _____

Name of Child: _____ Date of Birth: _____ Age: _____

Current School: _____ Current Grade: _____ Referral Source: _____

Child's Preferred Pronouns: She/Her He/Him They/Them Other: _____

Mother/Stepmother Name: _____ Father/Stepfather Name: _____

Phone Number: _____ Primary Care Physician: _____

Presenting Problem: (Please circle all that apply)

Very unhappy	Impulsive	Fire-setting
Irritable	Stubborn	Stealing
Temper outbursts	Disobedient	Lying
Withdrawn	Infantile	Sexual trouble
Daydreaming	Mean to others	School performance
Fearful	Destructive	Truancy
Clumsy	Trouble with the law	Bed-wetting
Overactive	Running away	Soiled pants
Slow	Self-mutilating	Learning problems
Short attention span	Head banging	Sleeping problems
Distractible	Rocking	Sickly
Undependable	Strange behavior	Alcohol use
Lacks initiative	Shy	Tobacco use
Peer conflict	Strange thoughts	Phobic
Strange thoughts	Suicide talk	Dependency on drugs

Explain:_____

_____

What are your primary goals for therapy, what do you want to see accomplished?

1._____

2._____

3._____

Current Family Situation:

Mother- Relationship to child

Natural Parent Stepparent Relative Adoptive Parent Foster Parent Age: _____

Occupation: _____ Education: _____ Religion: _____

Father- Relationship to child

Natural Parent Stepparent Relative Adoptive Parent Foster Parent Age: _____

Occupation: _____ Education: _____ Religion: _____

Marital status of natural parents:

Married Separated Divorced Deceased When: _____

If Child is Adopted:

Adoption source: _____

Reason and circumstances/What has the child been told? _____

Age when child was first in the home: _____ Date of legal adoption: _____

Living Arrangements:

Number of moves in the child's life:

Places	Dates

Present home:

Does the child share a room Yes No

If yes, with whom and their age? _____

If no, how long have they had their own room? _____

Has the child ever lived away from the family? Yes No

If yes, explain_____

What are the major family stresses at the present time, if any?_____

_____

Siblings (please indicate if step-siblngs)

Name	Age	Sex	School/Grade or Occupation	Living at home (yes or no)	Known use or treatment for drug abuse past or present (yes or no)

List all other extended family members by their relation to the patient who has drug and/or alcohol problems (legal or illegal), history of depression, Self-destructive behavior, or legal problems.

_____

_____

_____

Child Health Information: Please note all health problems the child has had or has now.

		Age			Age
	High Fevers			Dental Problems	
	Pneumonia			Weight Problems	
	Flu			Allergies	
	Encephalitis			Skin Problems	
	Meningitis			Asthma	
	Convulsions			Headaches	
	Unconsciousness			Stomach Problems	
	Concussions			Accident-prone	
	Head Injury			Anemia	
	Fainting			High or Low Blood Pressure	
	Dizziness			Sinus Problems	
	Tonsils Out			Heart Problems	
	Vision problems			Hyperactivity	
	Hearing Problems			Earaches	
	Infectious Diseases (explain)			Other Illnesses (explain)	

Has the child ever been hospitalized? Yes No

Age: ____ How Long: _____ Reason: _____

Has the child ever been seen by a medical specialist? Yes No

Age: ____ How Long: _____ Reason: _____

Has the child ever taken or are they currently on any prescribed medications? Yes No

Age: ____ How Long: _____ Reason: _____

Developmental History:

Was the child planned for? Yes No Were there any pregnancy complications? Yes No

Please explain any complications or illness during pregnancy: _____

_____

Length of pregnancy: _____ If Premature, how early? _____

If overdue, how late: _____ Birth weight: _____ Delivery:_____

Did the infant require oxygen or blood at delivery? Yes No

Did mother use/abuse alcohol/drugs during pregnancy? Yes No

Early Social Development:

Child's relationship with their siblings and peers:

Individual Play Group Play Competitive Cooperative Leadership Role Follower

Describe any special habits, fears, or idiosyncrasies of the child: _____

_____

_____

_____

_____

Educational History:

Type of classes:	Regular	Learning disability	Continuation
	Opportunity	Advanced	Other

Has the child skipped a grade?	Yes	No
Has the child repeated a grade?	Yes	No
Does the child have specific learning difficulties?	Yes	No
Has the child ever had a tutor or other special help with schoolwork?	Yes	No
Does the child attend school on a regular basis?	Yes	No
Does the child appear motivated for school?	Yes	No
Has the child ever been suspended or expelled?	Yes	No

Academic Performance:

Highest grade on last report card? _____

Lowest grade on last report card? _____

Favorite subject? _____

Least favorite subject? _____

Does the child participate in extracurricular activities? Yes No

In school, how many friends does the child have? A lot A few None

What are the child's educational aspirations? Quit Graduate College Tech/Vocational

Has the child had special testing in school? **Psychological** Yes No **Vocational** Yes No

If yes, what were the results? _____

List child's special interests, hobbies, skills: _____

_____

_____

_____

_____

Family History	**Depression**	**Anxiety**	**Bipolar Disorder**	**Schizophrenia**	**ADHD/ADD**	**Trauma History**	**Abusive Behavior**	**Alcohol Abuse**	**Drug Abuse**	**Incarceration**
Mother										
Father										
Sister										
Brother										
Maternal Uncle										
Paternal Uncle										
Maternal Aunt										
Paternal Aunt										
Maternal Grandmother										
Paternal Grandmother										
Maternal Grandfather										
Paternal Grandfather										

Has the child ever had difficulty with the police? Yes No

Has the child ever appeared in juvenile court? Yes No

Has the child ever been on probation? Yes No

If yes to any of the above, please explain.

_____

_____

Current Functioning:

Do you have concerns about your child in the following areas?

Eating Hygiene/Grooming Sleeping Activities/Play Social Relationships

Please rate your child's personality/temperament (how they behave the majority of the time in each of the following areas in a scale from 1 to 7. (Please circle the number that best describes your child:

Can sit still and listen for long periods of time	1	2	3	4	5	6	7	Can't sit still and listen for long periods of time
Enjoys routine; easily upset when day doesn't go as usual	1	2	3	4	5	6	7	Enjoys doing things differently; may not notice small changes in the day
Anxious- usually frustrated and worried	1	2	3	4	5	6	7	Calm- usually relaxed
Happy- usually enjoys what he/she is doing	1	2	3	4	5	6	7	Sad- usually unhappy; hard time having fun
Curious- usually eager to know something	1	2	3	4	5	6	7	Timid- usually not interested
Angry- easily frustrated and annoyed	1	2	3	4	5	6	7	Calm- usually composed and peaceful
Mild reaction- calm and cooperative easily pushed around by others	1	2	3	4	5	6	7	Strong reaction- may cry of yell over small things
Will stick to something until it is done	1	2	3	4	5	6	7	Gives up on tasks or has trouble finishing things
Learns by seeing, touching and using all of his/her senses	1	2	3	4	5	6	7	Has a strong reaction to noise, lights, hugging, or touching
Sympathetic to others; can use words to tell how he/she feels	1	2	3	4	5	6	7	Unaware of the feelings of others
Often fearful with new people and new situations	1	2	3	4	5	6	7	Will easily meet and accept new people and activities
Stays focused on tasks until completed	1	2	3	4	5	6	7	Easily sidetracked; difficulty following directions

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Patient Name: _____ DOB: _____ Date: _____

PHQA
(Age 11-17)

How often have you been bothered by the following over the past 2 weeks?

0- None; 1- Several days; 2- More than half the days; 3- Nearly every day

1) Have you been feeling down, depressed, irritable, or hopeless	**0**	**1**	**2**	**3**
2) Have you had little interest or pleasure in doing things	**0**	**1**	**2**	**3**
3) Have you had trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
4) Have you had a poor appetite, weight loss, or overeating	**0**	**1**	**2**	**3**
5) Have you been feeling tired or having little energy	**0**	**1**	**2**	**3**
6)Have you been feeling bad about yourself or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
7) Have you had trouble concentrating on things, like schoolwork, reading, or watching TV	**0**	**1**	**2**	**3**
8) Have you been moving or speaking so slowly that other people could have noticed? Or so fidgety or restless that you have been moving a lot more than usual	**0**	**1**	**2**	**3**
9) Have you had thoughts that you would be better off dead, or of hurting yourself in some way	**0**	**1**	**2**	**3**
10) In the past year have you felt depressed or sad most days, even if you felt okay sometimes?	**Yes**		**No**	
11) If you are experiencing any of the problems on this form, how difficult have these problems made it to do work, take care of things at home, or get along with others?	**None Somewhat Very Extremely**			
12) Has there been a time in the past month when you have had serious thoughts about ending your life?	**Yes**		**No**	
13) Have you ever, in your whole life, tried to kill yourself or made a suicide attempt?	**Yes**		**No**	

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GAD7
(Age 12 and up)

How often have you been bothered by the following over the past 2 weeks?

0- None; 1- Several days; 2- More than half the days; 3- Nearly every day

1) Have you been feeling nervous, anxious, or on edge	**0**	**1**	**2**	**3**
2) Do you feel that you have not been able to stop or control worrying	**0**	**1**	**2**	**3**
3) Have you been worrying too much about different things	**0**	**1**	**2**	**3**
4) Have you had trouble relaxing	**0**	**1**	**2**	**3**
5) Do you feel that you have been so restless that you find it hard to sit still	**0**	**1**	**2**	**3**
6) Have you been becoming easily annoyed or irritable	**0**	**1**	**2**	**3**
7) Have you been feeling afraid as if something awful might happen	**0**	**1**	**2**	**3**
8) If you checked any problem, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?	**None Somewhat Very Extremely**			