Southeast Kansas Mental Health Center

Face Sheet

ADAS ___Yes ___No _____%
DX _____
For CA Staff Use Only

Date _____ E-mail _____ Case No. _____

Name _____ Date of Birth _____ Age _____

Social Security # _____ Military/Veteran Status ☐ Yes ☐ No

Females Only: Maiden name _____ Former married names _____

Address _____ City/State/Zip _____

Phone # _____ Work Phone # _____

Cell Phone # _____ County of residence _____
We may contact you and/or leave a message regarding your appointment times unless instructed otherwise _____

If less than 6 months in this county, please specify previous county of residence _____

Do you have a legal guardian? ☐ No ☐ Yes If Yes, please provide the following:

Legal Guardian _____ Phone # _____

Address _____

Legal Custody Status (check one) ☐ A. No JJA/DCF involvement ☐ D. Child in JJA Custody/out-of-home
☐ G. Child in JJA custody/lives at home ☐ J. Under supervision of JJA/not custody
☐ M. Child in DCF custody/out-of-home ☐ P. Child in DCF custody/lives-at-home ☐ S. Under DCF supervision, not custody ☐ Other- Explain

Employment Status (check one) ☐ 2. Part-time (less than 35 hrs) ☐ 3. Full-time (more than 35 hrs) ☐ 4. Retired
☐ 5. Unemployed ☐ 6. Active Military Duty ☐ 7. Not in labor force

Marital Status (check one) ☐ 1. Never Married ☐ 2. Married ☐ 4. Divorced ☐ 5. Separated ☐ 6. Widowed
☐ 7. Common-law ☐ 00. Other

Student Status (check one) ☐ 1. Full Time Student ☐ 2. Part-time Student ☐ 3. Not a student
School _____

Race (check one) ☐ White ☐ Black or African American ☐ American Indian ☐ Alaskan Native
☐ Native Hawaiian ☐ Pacific Islander ☐ Asian ☐ Other

Ethnicity ☐ Hispanic ☐ NOT Hispanic

Primary Language _____ Other languages spoken _____

Primary Care Provider _____ Primary Care Provider Telephone # _____ Referred By _____

Gender (check one) ☐ 1. Male ☐ 2. Female ☐ 3. Transgender male to female ☐ 4. Transgender female to male

Party responsible for account _____ Relationship _____

Social Security # _____ DOB: _____ Email _____

Have you received previous mental health services? ☐ Yes or ☐ No If yes, please list:

Name of Facility	Address	Inpatient/Outpatient	Dates

Client Employment Information (if not employed, head of house employment information)

Employee Name _____

Employer _____ Occupation _____

Name (spouse) _____

Employer _____ Occupation _____

Address/City/State/Zip _____ Phone _____

List sources of household income*	Source	Gross Monthly Amount

* ***Proof of income must be attached for fee adjustment.***

List those dependent upon household income

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Emergency Contact Name _____ Telephone # _____

Address _____

You have the right to use Advance Directives. Please indicate below if you have written Advance Directives,. If not, a form can be provided, but is not required for treatment. ☐ Yes or ☐ No (Advanced Directives are your written health care choices).

Reimbursement Information

PRIMARY INSURANCE (attach copy) _____

ID # _____ Group # _____

Address _____ City _____ State/ZIP _____

Insured's Name _____ DOB _____

Client's relationship to insured _____

Benefit verification date _____ Pre-certification date & info. _____

SECONDARY INSURANCE (attach copy) _____

ID # _____ Group # _____

Address _____ City _____ State/ZIP _____

Insured's Name _____ DOB _____

Client's relationship to insured _____

Benefit verification date _____ Pre-certification date & info. _____

1. Is the patient a Veteran? ☐ Yes ☐ No
   a. Did the VA refer you here for treatment? ☐ Yes ☐ No
   b. Does the patient have a VA "fee basis ID card?" ☐ Yes ☐ No

   Veterans Administration Authorization: Does the patient authorize you to bill the VA? ☐ Yes ☐ No

2. Do you have a Federal Black Lung card? ☐ Yes ☐ No
   Are the services you are receiving today related to lung disease? ☐ Yes ☐ No
   If yes, submit claims to: Federal Black Lung Program, PO Box 740, Lanham, Maryland 20706

3. Is this medical condition due to an accident of any kind? ☐ Yes ☐ No
   If yes, was it: ☐ Work Related ☐ Auto ☐ Injured in own home ☐ Other

WORKER'S COMPENSATION INSURANCE INFORMATION

Date of accident _____ Employer Name and Address _____

Names of Workers Compensation Insurance _____

Name of Person or company Insured _____

Insurance company Claim or Policy # _____

Worker's compensation Claim # _____

Name of Worker's Compensation Agency where claim was filed _____

Address _____

Has the case been settled ☐ Yes Date _____ ☐ No

Name of Patient's Legal Representative in this case (if any) _____

Phone number of Legal Representative _____

AUTOMOBILE, NO-FAULT OR LIABILITY INSURANCE INFORMATION:

Date of Accident: _____ If other than auto, describe accident _____

Business /Property Owner _____ Address: _____ Telephone#: _____

Type of insurance: Premises Medical _____ Liability _____

Name of Policy holder _____ Address of Policyholder _____

Policy Number or Claim ID Number _____ Insurance Company _____

Address of Insurance company _____

Legal Representative& Phone number for this case (if any) _____

Southeast Kansas Mental Health Center

Agreement for Financial Responsibility

Client _____ Case # _____

2019		***Fees are subject to change without notice***	
Type of Service		Unadjusted Fee	Adjusted Fee**
Assessment (Counselor or QMHP)	90791	$ 200.00 per hour	$
Assessment (Psychiatrist)	90792	$ 210.00 per hour	$
Individual/Family Therapy (Counselor or QMHP)	90837	$ 210.00 per hour	$
Group Therapy	25000	$ 90.00 per hour	$
Community Psychiatric Support	31000	$ 140.00	$
Medication Review	99213	$ 130.00 per hour	$
Injections	96372	$ 40.00 per appointment	$
Targeted Case Management	34000	$ 25.00 per unit*	$
Attendant Care	33000	$ 10.00 per unit*	$
Psychosocial Group	32000	$ 10.00 per unit*	$
Peer Support (Individual)	35000	$ 15.00 per unit*	$
Outpatient Treatment Program Chemical Abuse Services	90837	$ 210.00*	$
Psychological Evaluation	14000	$ 210.00 per hour	XXXX
Alcohol/Drug Diagnostic Evaluation	90791	$150 per evaluation***	XXXX
Alcohol/Drug Information School (Adult)	61000	$100.00***	XXXX
Alcohol/Drug Information School (Adolescent)	61000	$50.00***	XXXX
Tobacco Cessation	90829	$60.00	XXXX
Tobacco Cessation Class	25200	$40.00	XXXX

** - A unit is 15 minutes.* *** - Proof of income must be attached before fee is adjusted.* ****-No fee adjustment.*

PLEASE READ THIS CONTRACT BEFORE SIGNING

I authorize use of this form for all my insurance submissions.
I authorize the Center to act as my agent in helping me obtain payment from my insurance.
I authorize payment directly to the Center for services rendered. I understand that a claim will be filed at the unadjusted cost per hour. If my insurance does not reimburse the Center in the amount of my fee, I understand that I am responsible for my bill.
I authorize the Center to disclose information needed for billing purposes to all my insurance companies. I acknowledge receipt and I have reviewed and understand the Financial Policies. I agree to comply with these policies.
I understand that 24 hours notice is required when canceling or rescheduling my appointment and that missed appointments will be charged at the sliding scale rate.
I certify that I have received the Guide to Services, Welcome brochure, and Notice of Privacy Practices, and Clients Rights.
I certify that I understand my rights and responsibilities.
I certify that I have provided accurate information.
I certify that I have read and agree to this contract.
I certify that the fee was discussed with me.

_____ _____ _____

Client/Parent or Legal Representative Date Witness

PLEASE MAKE COPY FOR CLIENT - ORIGINAL IS FILED IN CASE RECORD

Southeast Kansas Mental Health Center

Informed Consent For Voluntary Initial Assessment and Treatment

Client Name: _____

I understand that by signing this consent for initial assessment and treatment that I am agreeing to participate in an evaluation at Southeast Kansas Mental Health Center. The purpose of this evaluation is to assess my current mental health or substance abuse needs and to develop specific treatment recommendations related to my concerns that have brought me to the Center.

I understand that the initial evaluation will be conducted by _____.

The evaluation will consist of interviews, but I may also be asked to participate in psychological testing to more thoroughly assess my needs.

I understand that my therapist may need to discuss my case in a confidential manner with a professional associate and/or supervisor for the purpose of providing higher quality service to me. I am aware that I may be asked to see additional professional staff who may participate in my evaluation and treatment. I understand that these discussions will be kept confidential unless I authorize that information be released or unless allowed or required by law. These exceptions to confidentiality are specified in the *Privacy Policy* of which I have been given a copy.

I understand that some treatment recommendations may be addressed during the initial interview(s). Once the evaluation is complete and an initial treatment plan has been formulated, I will be given the opportunity to review and discuss with my therapist my diagnosis and treatment, including alternatives to these recommendations.

I understand that this consent is voluntary and that I can withdraw my consent to treatment at any time.

I understand that some services may be made available through telemedicine and not in person with a provider. I have the right to not have services provided by telemedicine.

I hereby consent to participate in the process of assessment and treatment at Southeast Kansas Mental Health Center.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Signature Date

Southeast Kansas Mental Health Center

CHILD & ADOLESCENT INTAKE ASSESSMENT[1]

This information is part of your confidential medical record. Your answers are important to providing the best possible treatment. Please answer as many questions as possible. Mark any questions you prefer to answer in person.

Clinician Use Only: *ID:* _____ *Date* _____
Time In/Out: _____ *Units:* _____
Intake Assessment, Code: ☐ *ADMN (New) or* ☐ *ADMR (Reopen)*

IDENTIFYING INFORMATION

Client Name: _____ DOB: _____ Age: _____

☐ Male ☐ Female Height: _____ Weight: _____ lbs.

Distinguishing physical characteristics (i.e., hair color, disabling condition, etc.): _____

_____

Physical Aids Present (i.e., glasses, cane, walker, hearing aid, etc.): _____

_____

School Status: _____ Cultural Identity: _____

Living with Whom? _____ How long in area? _____

Type of Residence: _____ Who referred you? ☐ self ☐ friend
☐ family member ☐ law enforcement
☐ mental health professional ☐ physician/nurse
☐ ad in phone book ☐ minister
☐ agency ☐ co-worker
☐ Other _____

PARENT INFORMATION

Your Name: _____ Age: _____

Other parent in residence Name: _____ Age: _____

How long have you been the primary caretaker? _____

Do you share joint custody? ☐ yes ☐ no If yes, how long? _____
If divorced, does the other custodial parent agree services should be sought? ☐ yes ☐ no ☐ don't know
Will both parents in residence be involved in treatment? ☐ yes ☐ no ☐ don't know
Will both biological parents be involved in treatment? ☐ yes ☐ no ☐ don't know

[1]Adapted from instrument of Western Arkansas Counseling and Guidance Center, Ft. Smith, Arkansas (2005), used with permission.

If divorced, other Biological Parent's Name: _____ Age:_____

Address: _____ City/State/Zip:_____

Home Phone: _____ Work Phone: _____ Message Phone: _____

If there is joint custody, list any recent problems _____

PRESENTING PROBLEMS

What is the MOST SIGNIFICANT problem or reason for seeking help today? _____

_____

How would you rate the severity of this problem? ☐ moderate ☐ significant ☐ extrene

How long this been a problem? _____

How often does the problem occur? ☐ constantly ☐ daily ☐ weekly ☐ monthly ☐ less often

Has there been:
Suicide thinking or attempts ☐ In the last month? ☐ Today ☐ _____

Thoughts of harming others or attempts ☐ In the last month? ☐ Today ☐ _____

How difficult was it to get your child or adolescent to come for help? _____

In what ways have the problems troubled you? _____

_____

Is there a court order to receive treatment? ☐ yes ☐ no

On the next page are some common problem areas for children/adolescents. To help focus on the most important issues, please complete the following checklist.

1) ☑ Check only **Problem Areas** with moderate or greater distress.
2) For each checked, also check the level of **Distress**, how long this has been a problem (**Duration**) and how often problem **Occurs**.

	PROBLEM AREAS	DISTRESS			DURATION					OCCURS				
		Moderate	Significant	Extreme	Less than 6 months	6 - 12	12 - 24	over 24		Constantly	Daily	Weekly	Monthly	Less often
☐	Academic Underachievement	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Adoption/Foster Care Issues	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Anger Management / Temper	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Antisocial Behavior / Legal System	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Anxiety or Panic	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Attachment Issues	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Attention/Concentration Problems	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Bedwetting/Soiling/Toileting	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Blended Family Problems	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Bullying or Intimidating Others	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Childhood Trauma	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Chronic Pain/Physical Problems	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Conduct Disorder/Delinquency	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Dependency/Separation Anxiety	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Depression	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Disruptive/Attention Seeking	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Divorce Adjustment	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Eating Disorder	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Family Conflict	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Fire Setting	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Impulse Control	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Losing Touch With Reality	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Low Self-Esteem	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Lying or Manipulative	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Obsessive and/or Compulsive	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Oppositional/Defiant/"doesn't mind"	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Paranoid/Suspicious	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Peer/Sibling Conflict	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Phobias/Fears	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Physical Abuse	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Relationship Conflicts	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	School Related Problems	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Sexual Abuse	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Sexual Confusion or Behavior	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Sleep Disturbance	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Social Discomfort	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Social Skills Deficits	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Speech/Language Difficulties	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Spiritual Confusion	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Substance Abuse/Dependence	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Suicidal Thoughts/Attempts	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Unresolved Grief/Loss	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐
☐	Other:	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐

What do you hope to get from treatment?_____

_____

What do you expect from your treatment team? _____

_____

What do you think your role in treatment will be? _____

Who else, such as family members or friends, will be involved in treatment? _____

_____

What **problems** or **needs** do you have that might hinder treatment or ability to reach your desired goals?

_____

What **preferences** do you have regarding your treatment program at Southeast Kansas Mental Health Center? For example, is there a service that you do not want?

_____

_____

_____

_____

_____

_____

_____

CHILD/ADOLESCENT STRENGTHS, ABILITIES, NEEDS & PREFERENCES

What are **two (2)** resources **(strengths)** of your child or adolescent that will help in treatment?

- ☐ Family Support
- ☐ School
- ☐ Intelligence
- ☐ Network of Friends
- ☐ Stable Finances
- ☐ Good Health
- ☐ Spiritual
- ☐ Available Transportation
- ☐ Other: _____

Your child or adolescent possesses many different **abilities** that can be utilized to help overcome problems. What are **four (4)** of abilities that may be most useful in treatment? He or she can . . .

- ☐ take medication
- ☐ work cooperatively with others
- ☐ request help from others
- ☐ use self-help materials
- ☐ follow directions
- ☐ maintain consistent behavior
- ☐ be assertive
- ☐ provide leadership
- ☐ resolve conflicts
- ☐ keep appointments
- ☐ complete tasks assigned
- ☐ other: _____
- ☐ express thoughts and feelings
- ☐ abstain from alcohol/drugs
- ☐ analyze problems
- ☐ develop solutions to problems
- ☐ manage time effectively
- ☐ other: _____

FAMILY AND SIGNIFICANT RELATIONSHIPS

Child / Adolescent raised by? ☐ parents ☐ grandparent(s) ☐ single parent ☐ Other _____

What do you think about how your child was raised?_____

_____

What kind of relationship do you have today with your child? _____

How many brothers or sisters does you child have? _____

What kind of relationship does your child have with his or her brothers and sisters?_____

_____

Parent Marital Status?

☐never married ☐married ☐divorced ☐separated ☐widow(er) ☐living as married

How many times have you been married?_____ How long each time?_____

_____

Total number of children: ___his ___hers ___ours. If children live with you, please give:

Name: _____ Age___ Sex___ ☐ his ☐ hers ☐ ours

Name: _____ Age___ Sex___ ☐ his ☐ hers ☐ ours

Name: _____ Age___ Sex___ ☐ his ☐ hers ☐ ours

Name: _____ Age___ Sex___ ☐ his ☐ hers ☐ ours

What problems exist in your current intimate relationship? _____

_____

How much stress do you feel from parenting? ☐ None ☐ Some ☐ A lot ☐ Overwhelmed

How many close friends do you have? _____ How well do you get along with others? _____

To what organizations, clubs or teams do you belong? _____

_____

What problem(s) have you, your spouse and other children had? What about extended family?

Problems with	Father	Father's Mother	Father's Father	Father's Brother(s)	Father's Sister(s)	Father's Uncle(s)	Father's Aunt(s)
Aggressiveness, defiance as a child							
Attention, overly active, impulse control as a child							
Learning disabilities							
Dropped out of school							
Mental Retardation							
Psychosis or schizophrenia							
Depression for more than two (2) weeks							
Anxiety disorder that impaired work							
Tics or Tourette's Disorders							
Alcohol and/or Drug Abuse							
Law Enforcement							
Physical Abuse							
Sexual Abuse							

Problems with	Mother	Mother's Mother	Mother's Father	Mother's Brother(s)	Mother's Sister(s)	Mother's Uncle(s)	Mother's Aunt(s)
Aggressiveness, defiance as a child							
Attention, overly active, impulse control as a child							
Learning disabilities							
Dropped out of school							
Mental Retardation							
Psychosis or schizophrenia							
Depression for more than two (2) weeks							
Anxiety disorder that impaired work							
Tics or Tourette's Disorders							
Alcohol and/or Drug Abuse							
Law Enforcement							
Physical Abuse							
Sexual Abuse							

Child's or Adolescent's Brothers and Sisters -- WRITE IN *FIRST NAME(s)* IF A PROBLEM

Problems with	Brother(s) First Name(s)	Sister(s) First Name(s)
Aggressiveness, defiance behavior as a child		
Attention, overly active, and/or poor impulse control as a child		
Learning disability		
Dropped out of school		
Mental Retardation		
Psychosis or schizophrenia		
Depression lasting more than two (2) weeks		
Anxiety disorder than impaired school work		
Tics or Trourette's Disorders		
Alcohol and/or Drug Abuse		
Law Enforcement		
Physical Abuse		
Sexual Abuse		

DAILY ACTIVITY STRENGHTS AND LIMITATIONS

CHILD / ADOLESCENT DAILY ACTIVITIES[1]		Mark the following (S) if STRENGTH Or (L) if LIMITATION If neither, leave blank
1. Personal Care	Helps or manages general cleanliness: daily bath, shower, brush teeth	
2. Grooming	Assists or manages general appearance: hair, shave, comply with school rule	
3. Dress	Assists or responsibly cares for clean clothes, comply with school dress code	
4. Household Stability	Contributes to stability in the home (age-wise): respects others & property, shares in chores, involves caretakers in school-related projects, grades	
5. Physical & Mental Health	Assists or manages adequate weight, moods, outdoor exercise, aches; takes medications or over-the-counter drugs only with adult supervision.	
6. Communicate	Greets adults; listens, expresses feelings, anger, opinions effectively.	
7. Safety within environment	Plays it safe? Avoids guns, knives, matches, dangerous people or places where there likely is trouble or abuse; if driving, has safe record.	
8. Managing Time	Assists or manages time for promptly, regularly attending school & work (age-appropriate); completes tasks, sleeps, wakes up, eats on regular basis?	
9. Managing Money	Reliably handles or manages monetary allowance: abstains from overspending personal limits, betting, stealing, and borrowing?	
10. Nutrition	Eats at least 2 basically nutritious meals with caretakers; eats healthy snacks.	
11. Problem Solving	Understands presenting problems, reasons for seeking services; focuses on possible solutions for age-appropriate time periods; assists or manages difficult situations	
12. Family Relationships	Feels close to at least one other person at home; gets along with family or caretakers, feels loved?	
13. Alcohol, Drug Use	Abstains from smoking cigarettes, drinking alcohol, doing drugs or inhalants of any kind; avoids high risk drinking situations & people who use drugs	
14. Leisure Entertainment	Enjoys 2 or more fun & relaxing activities: music, watching or playing sports, reading, computer-board games, cards, artistic hobbies, movies, TV?	
15. Community Resources	Uses community activities, resources: after-school sponsored tutoring, clubs, sports, Scouts, YM/YWCA, library, church, dance.	
16. Peers/Social	Makes, keeps same-age friends; avoids bullying, gangs, cults, antisocial groups	
17. Sexual Behavior	Behavior is sexually responsible with girls, boys (and age-appropriate)? Avoids sexual activities, infections, pregnancy?	
18. Work & Productivity	Feels good about performance at school, considers grades to be good, completes school projects without undue difficulty. Has vocational goals.	
19. Coping Skills	Accepts adult correction without undue arguing, temper outburst; tolerate frustration, copes with disappointments, retains self-worth.	
20. Behavior Norms	Controls threatening or physical expression of anger, violent behaviors--either to self or others or to property. Law-abiding and responsible with rules, car, etc.	

[2]Adapted from Daily Living Activities Scale, Willa Pressmanes, used with permission.

DISCIPLINE

What methods have been used to discipline the child or adolescent?	Successful	Unsuccessful
Verbal reprimands		
Time out (isolation)		
Removal of privileges		
Removal of toys or activities		
Rewards		
Physical punishment		
Spend time with		
Let them have their way		
Avoid conflict		

How often does your child or adolescent comply with your first command? ☐ Always ☐ Never
☐ More than half the time ☐ Less than half the time

How often does your child or adolescent eventually comply with your commands? ☐ Always ☐ Never
☐ More than half the time ☐ Less than half the time

How much agreement and consistency do you and your spouse show in discipline? ☐ Always ☐ Never
☐ More than half the time ☐ Less than half the time

SPIRITUAL BACKGROUND

Are you a member of a local religious group? ☐ yes ☐ no Which one? _____
How active are you? ☐ extremely ☐ very ☐ somewhat ☐ not at all
How important is your faith? ☐ extremely ☐ very ☐ somewhat ☐ not at all

How might your faith/spirituality help? _____
Is there any spiritually related information you would like to add?

DEVELOPMENTAL FACTORS

Mother's health during pregnancy? ☐ Good ☐ Fair ☐ Poor ☐ Don't know

Alcohol consumed during pregnancy? ☐ yes ☐ no If yes, how much? _____

Street Drugs consumed? ☐ yes ☐ no If yes, used _____

During pregnancy used Tranquillizers (Valium, Librium, Xanax)? ☐ Cigarettes? ☐ Diabetes medication?
☐ Coffee or caffeine drinks? ☐ Seizure Medication? ☐ Antibiotics? ☐ Sleeping Medication?
☐ Psychiatric Medication _____

Number of previous pregnancies? _____ This delivery was ☐Normal? ☐Early? ☐ Long Labor?
☐Eclampsia? ☐Problem of Toxemia? ☐Rh Incompatibility? ☐Unusual Stress? ☐Breech delivery?
☐Water broke more than 24 hours early? ☐Induced delivery? ☐Forceps? ☐Cesarean?
☐Birth Defects? _____

As an infant, child was ☐Normal? ☐Slow? ☐Advanced? ☐Other_____

_____

As a toddler, child was ☐Normal? ☐Slow? ☐Advanced? ☐Other_____

_____

☐Bladder training problems? If so, started at age _____ He or she _____

☐Bowel training problems? If so, started at age _____ He or she _____

☐Ear problems? If so, started at age _____ He or she _____

☐Sleep problems? If so, started at age _____ He or she _____

☐Eating problems? If so, started at age _____ He or she _____

☐Other pre-school problems?_____

MEDICAL HISTORY

How is your child's or adolescent's health? ☐Very Good ☐Good ☐Fair ☐Poor ☐Very Poor

He or she has been treated for ☐Hearing ☐Vision ☐Coordination ☐Speech ☐Breathing

☐ Chronic health problem(s): _____

Has your child or adolescent had any of the following illnesses?

Mumps	☐	Chicken Pox	☐
Measles	☐	Whooping Cough	☐
Scarlet Fever	☐	Pneumonia	☐
Encephalitis	☐	Ear Infections	☐
Seizures	☐	Lead Poisoning	☐
Allergies	☐	Frequent runny nose	☐
Frequent Colds	☐	Frequent sinus infection	☐

Other: _____

Has your child or adolescent had any of the following accidents?

Broken bones	☐	Severe lacerations	☐
Head injury	☐	Severe bruises	☐
Stomach pumped	☐	Eye injury	☐
Lost teeth	☐	Sutures	☐

Other: _____

Has your child or adolescent had any of the following?

Tonsillitis	☐	Adenoids	☐
Hernia	☐	Appendicitis	☐
Eye, ear, nose, & throat	☐	Digestive Disorder	☐
Urinary tract	☐	Foot, Leg or Arm Disorder	☐
Burns	☐	Diabetes	☐

Other: _____

Has your child or adolescent had any of the following symptoms in the past 60 days?

Ankle Swelling	Coughing	Lightheadedness	Penile Discharge	Urination Difficulty
Breathing Difficulty	Pulse Irregularity	Memory Problems	Cramps	Bedwetting
Vomiting	Vision Changes	Seizures	Vaginal Discharge	Blood in Stool
Muscle Weakness	Shakiness	Dizziness	Nervousness	Diarrhea
Mole/Wart Changes	Tremor	Falling	Sleep Problems	Constipation
Hair Change	Nosebleeds	Confusion	Gait Unsteadiness	Sweats (Night)
Hearing Loss	Chest Pain	Panic Attacks	Numbness	Sweats (Other)
Headaches	Tingling in Arms & Legs	Loss of Consciousness	Rash	Bleeding gums

SEXUAL HISTORY (Reminder: You may choose not to answer any of the following questions)

Did your family or school provide sex education?	☐ yes	☐ no	
Is there a problem with sexual behavior?	☐ yes	☐ no	
Was child ever forced to have sexual contact?	☐ yes	☐ no	When? _____
Has he or she contracted a sexually transmitted disease?	☐ yes	☐ no	
Sexually active in any way?	☐ yes	☐ no	

What other significant sexually oriented problems do you wish to discuss?

LEGAL HISTORY (Reminder: You may choose not to answer any of the following questions)

Has your child or adolescent had contact with law enforcement?	☐ yes	☐ no
Has you child or adolescent ever been arrested or taken to court?	☐ yes	☐ no
Has your child or adolescent ever been placed in a correctional institution?	☐ yes	☐ no

If yes, when? _____ How Long? _____ Where? _____

Current legal issues or problems? _____

MENTAL HEALTH HISTORY & TREATMENT

☐ Check here if child or adolescent has never been in mental health treatment

OUTPATIENT TREATMENT HISTORY

Treated By:	From: Date to Date		For What Problems?	Results of Treatment

PSYCHIATRIC HOSPITALIZATIONS

Hospital:	From: Date to Date		For What Problems?	Results of Treatment

PSYCHIATRIC MEDICATIONS

Medication	Amount	Prescribed By:	Taken From Date to Date		Results of Treatment

What mental health related information would you like to add?

After completing treatment, how do you plan to maintain progress? _____

_____

Thank you for taking the time to complete this background information.
Please place this in the envelope provided, put your name on the outside and seal to insure privacy.
Bring to your appointment.

Southeast Kansas Mental Health Center

Electronic Communication Consent

Client Name: _____
DOB: _____
SSN: _____

Purpose: Consent to allow SEKMHC staff to correspond by e-mail/text message to myself. These can be used for scheduling, appointment reminders, billing, and other forms of client communication/information. I am responsible for providing SEKMHC with current email address and cell phone number.

Cell Phone/Text Number: _____ Email address: _____

Cell Phone/Text Number: _____ Email address: _____

E-Mail and Text Messaging Risk Factors and Responsibilities

Risks:

- Emails can be circulated, forwarded, and stored in numerous paper and electronic files.
- Email or text messages can be sent out and received by many recipients, some or all of whom may be sent the message accidently.
- Emails/text messages are not always encrypted and could be read by someone with the skills to do so.
- Email or text messages senders could misaddress a message.
- Emails or text messages are easier to falsify than handwritten or signed documents.
- Even if someone deleted an email or text message, there may still be a backup copy.
- Employers and on-line services may have a right to archive or inspect emails/text messages transmitted.
- Email/text messages can be intercepted, altered, forwarded or used without authorization or detection.
- Emails or text messages are a part of the client's file and therefore can be used as evidence in court.
- Emails or text messages can be used to introduce viruses into computer systems.

Conditions for use:

- We can't guarantee that email or texts will be read, received or responded to within a particular time frame.
- No one should use text or email for emergencies or any matter that is time sensitive in nature. Please call 911, the crisis line or go to the nearest ER for care.
- Texting and emails are to be used during business hours and not to be used after hours or during weekends and holidays and we can't guarantee a response during these times.
- All emails or text messages received or sent may be made part of the client record.

- Messages may be forwarded internally via email to staff.
- Messages may be forwarded to independent third parties with signed release on file.
- The center uses Facebook, has a website, and third-party applications that we use to connect with the community and to provide tools to assist with problem solving/learning skills. If you use these sites to connect with us, we can't guarantee confidentially on these sites.

By signing below, I agree to Electronic Consent Form and request that my provider communicate with me electronically. I can revoke in writing at any time. I understand risks involved and agree to the conditions above. The center may use third party applications, and these will be explained to me at the time. I hereby release, discharge and agree to hold harmless all parties to whom this consent is given from any liability that may arise from the release of information authorized below.

Messages may be communicated to me via email, cell phone and by texting/SMS on my cell phone.

_____ _____

*Client or Client's Parent/Legal Guardian Signature Date

_____ _____

Printed Name Print Relationship to client (if other than self)

_____ _____ _____

Signature of Witness (Print Name) Date