Patient Registration

Name: _____

DOB: _____/_____/_____ **SSN:** _____-_____-_____ **Sex:** F M

Address (no P.O. Box): _____

City/ State/ Zip: _____

Home phone :(_____) _____-_____ **Cell phone :**(_____) _____-_____

Email:_____ **Preferred method of contact**_____

Emergency Contact:

Name: _____**Phone:** (_____) _____-_____

Referred by: _____

Insurance Information:

Do you have insurance?

☐ **Yes** (if you have insurance, check and complete below)	☐ **No**

☐ **BCBS of MN subscriber ID #:**_____

☐ **Prime West Health subscriber ID #:**_____

Policy Holder's Name:_____ **Policy Holder's Birthday:**_____/_____/_____

Client Rel. to Insured: Self Spouse Child Other:_____

Policy #:_____

Group Plan #:_____

Yes: ☐ **No:** ☐ I hereby certify that the above statements are correct.
Yes: ☐ **No:** ☐ I authorize the release of any medical information necessary to process insurance claims.
Yes: ☐ **No:** ☐ I authorize benefits for services to be paid directly to Integrative Health & Wellness Inc.

Signature:_____ Date ____/ _____/ ____

For Office Use Only:

Diagnosis Code: _____ Insurance Verification: Caller Initials _____
Effective Date of Coverage: _____ Insurance Co Contact: _____
Deductible (Cal Yr/Contract Yr): _____ Benefits (copay or %): _____

Consent to Treatment and Recipient's Rights

Client_____

I, _____ the undersigned, attest that I have Voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship (mentioned above), to enter into treatment at Integrative Health and Wellness Inc. (IHW). Further, I consent to have treatment provided by Integrative Health and Wellness Inc. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The clinic encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content.

Nonvoluntarily Discharge from Treatment: A client may be terminated from IHW nonvoluntarily. if: (A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or (B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the nonvoluntary discharge by letter. The client may appeal this decision with the Clinic Director or request to reapply for services at a later date.

Client Notice of Confidentiality: The confidentiality of patient records maintained by IHW are protected by federal and/or state law and regulations. Generally, IHW may not say to a person outside IHW that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: (1) the patient consents in writing, (2) the disclosure is allowed by a court order, or (3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of federal and/or state law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or state law and regulations do not protect any information about a crime committed by a patient either at IHW, against any person who works for IHW, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under federal and/or state law to appropriate state or local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is IHW's duty to warn any potential victim when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of nonemancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the above-stated policies and agreements with Integrative Health and Wellness Inc.
This consent will expire automatically after 1 year from the date on which it is signed, or upon fulfillment of the purposes stated above. This consent may be terminated at any time by a written notice from the client or legal guardian.

_____ Date ____/ _____/ ____
Signature of Client/Legal Guardian

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

_____ Date ____/ _____/ ____
Witness

Recipient's Rights Notification

As a recipient of services at our facility, we would like to inform you of your rights as a patient.
The information contained in this form explains your rights and the process of complaining if you believe your rights have been violated.

Your rights as a patient

1. Complaints. We will investigate your complaints.
2. Suggestions. You are invited to suggest changes in any aspect of the services we provide.
3. Civil rights. Your civil rights are protected by federal and state laws.
4. Cultural/spiritual/gender issues. You may request services from someone with training or experiences from a specific cultural, spiritual, or gender orientation. If these services are not available, we will help you in the referral process.
5. Treatment. You have the right to take part in formulating your treatment plan.
6. Denial of services. You may refuse services offered to you and be informed of any potential consequences.
7. Record restrictions. You may request restrictions on the use of your protected health information; however, we are not required to agree with the request.
8. Availability of records. You have the right to obtain a copy and/or inspect your protected health information; however, we may deny access to certain records. If so, we will discuss this decision with you.
9. Amendment of records. You have the right to request an amendment in your records; however, this request could be denied. If denied, your request will be kept in the records.
10. Medical/legal advice. You may discuss your treatment with your doctor or attorney.
11. Disclosures. You have the right to receive an accounting of disclosures of your protected health information that you have not authorized.

Your rights to receive information

1. Medications used in your treatment. We will provide you with information describing any potential risks of medications prescribed at our facility.
2. Costs of services. We will inform you of how much you will pay.
3. Termination of services. You will be informed as to what behaviors or violations could lead to termination of services at our clinic.
4. Confidentiality. You will be informed of the limits of confidentiality and how your protected health information will be used.
5. Policy changes.

Our ethical obligations

1. We dedicate ourselves to serving the best interest of each client.
2. We will not discriminate against clients or professionals based on age, race, creed, disabilities, handicaps, preferences, or other personal concerns.
3. We maintain an objective and professional relationship with each client.
4. We respect the rights and views of other mental health professionals.
5. We will end services or refer clients to other programs when appropriate.
6. We will evaluate our personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. We will continually attain further education and training.
7. We respect various institutional and managerial policies but will help to improve such policies if the best interest of the client is served.

Patient's responsibilities

1. You are responsible for your financial obligations to the clinic as outlined in the Payment Contract for Services.
2. You are responsible for following the policies of the clinic.
3. You are responsible to treat staff and fellow patients in a respectful, cordial manner in which their rights are not violated.
4. You are responsible to provide accurate information about yourself.

What to do if you believe your rights have been violated

If you believe that your patient rights have been violated, contact our Clinic Director at:
819 Paul Bunyan Dr. S.
Bemidji, MN 56601

Or call
(218) 444-3161.

EMDR Acknowledgement & Consent

I have been advised and understand that Eye Movement Desensitization and Reprocessing (EMDR) is a treatment approach that has been widely validated by research for use with Post Traumatic Stress Disorder (PTSD). Research on other applications of EMDR is now in progress.

I have also been specifically advised of the following:

1. Distressing, unresolved memories may surface through the use of the EMDR procedure. Some clients have experienced reactions during the treatment sessions that neither they nor the administering clinician may have anticipated, including a high level of emotion and/or physical sensations.

2. Subsequent to the treatment session, the processing of incidents and/or material may continue, and other dreams, memories, flashbacks, feelings, etc., may surface.

Before commencing EMDR treatment, I have thoroughly considered all of the above information. I have obtained whatever additional input and/or professional advice I deemed necessary and/or appropriate to making an informed decision concerning my participation in EMDR treatment.

By my signature below, I consent to receiving EMDR treatment from Jodi Anderson, MSW, LICSW.

My signature on this Acknowledgement and Consent Form is free from pressure or influence from any person or entity.

This consent will expire automatically after 1 year from the date on which it is signed, or upon fulfillment of the purposes stated above. This consent may be terminated at any time by a written notice from the client or legal guardian.

_____ Date ____/ _____/ ____
Signature of Client/Legal Guardian

_____ Date ____/ _____/ ____
Witness

Release of Information Consent

Client's Name: _____

Address: _____City:_____State:_____Zip Code: _____

Phone: _____ DOB: _____/_____/_____

I, _____, authorize **Integrative Health & Wellness Inc**. to

send/receive the following **to/from** Name(Agency/Person): _____
(circle above) (circle above)

Address: _____City:_____State:_____Zip Code: _____

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR PSYCHOTHERAPY NOTES.

_____ Academic testing results
_____ Behavior programs
_____ Progress reports
_____ Intelligence testing results
_____ Medical reports
_____ Personality profiles
_____ Psychological reports
_____ Psychological testing results
_____ Service plans
_____ Summary reports
_____ Vocational testing results
_____ Entire record, except progress notes
_____ Psychotherapy notes
_____ Others, specify _____

The above information will be used for the following purposes:

_____ Planning appropriate treatment
_____ Continuing appropriate treatment
_____ Determining eligibility for benefits
_____ Case review _____ Updating files
_____ Coordinate Care
_____ Other (specify) _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.
I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice. After 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization. **This consent will expire automatically after 1 year from the date on which it is signed, or upon fulfillment of the purposes stated above. This consent may be terminated at any time by a written notice from the client or legal guardian.**

Your relationship to client: ____Self ____Parent/legal guardian ____Legal representative

____Other (describe) _____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Date ____/ _____/ ____

Signature: _____ Date ____/ _____/ ____
Parent/guardians/personal representative (if applicable)

Signature: _____ Date ____/ _____/ ____
Witness (if client is unable to sign)

Payment Contract for Services

Client Name _____ Date _____/_____/_____

- A therapy hour is 45-50 minutes. $175 per session is payable at the start of each therapy hour, unless other arrangements have been made. Payment may be made with cash or credit card. No checks will be accepted.
- A credit card will be on file and charged for any outstanding balances at the end of each business day. This includes session fees, missed appointments, insurance copays and patient responsibilities. A convenience fee of $5 will be applied for each credit card transaction.
- A discount of $25 per session applies if cash is paid in full at the time of service.
- The client is fully and directly responsible to Integrative Health & Wellness Inc. for the payment of services rendered.
- Insurance coverage differs, so please check with your insurance company to determine the requirements for mental health coverage.
- If payment becomes a problem, you are encouraged to discuss this directly with your therapist to consider other alternatives.
- If fees change during the course of treatment, you will be given adequate notice of these changes.
- **You will be charged the full session fee of $175 for missed appointments or appointments cancelled with less than a 24-hour notice** (except in cases of illness, emergency or severe weather).
- Fees for telephone contacts or to prepare reports (for court, insurance companies or other entities) will be pro-rated, based on the standard hourly rate.
- Balances 30 days or more overdue will be assessed a late fee of $25 at the end of each monthly billing cycle.

Card information

Card Holder's Name _____

Last 4 Digits of the Card Number ___ ___ ___ ___ Card Type: _____Visa / Master Card / any other type_____

Valid Thru _____MM_____ / _____YYYY_____ Billing Zip Code _____ CVC _____

I understand my responsibility for payment of fees. Please select one of the following payments options:

_____Initials_____ I am registering as a **private pay client** and understand payment is due prior to services.
Waiver of Insurance Billing: I understand by receiving a cash payment discount, Integrative Health & Wellness Inc. will not bill insurance for services provided under this arrangement. No forms will be produced now, or in the future, for insurance billing purposes**. I agree to waive insurance billing by Integrative Health & Wellness Inc.**

OR

_____Initials_____ I authorize Integrative Health & Wellness Inc. to provide information to my insurance carrier(s) concerning any services rendered to me or any member of my family. I understand it is my responsibility as the client to know and understand my insurance coverage/benefits. It is my responsibility to call my insurance company to verify services before services are rendered. If insurance does not pay for services received, I understand I am financially responsible to pay for these services.

I have been given a copy of the current fee policy and have been given the opportunity to discuss my financial situation with my therapist. I understand I will be responsible for all fees as indicated and as outlined on this payment contract. I authorize Integrative Health and Wellness to charge the balance due to the credit card on file.

_____ Date ____/ _____/ ____
Signature of Client/Legal Guardian

_____ Date ____/ _____/ ____
Witness

CARD TYPE

CARD NUMBER

EXPIRATION DATE

\- - - /

CARD HOLDER NAME

CVC

BILLING ZIPCODE

Rates and Insurance

EMDR Individual Therapy Rates

Fees are payable at the beginning of the session by cash or credit card unless other arrangements have been made. Discounts only apply if sessions are paid with cash at the session.

45-55 minute session

- $175 if paid by credit card or after your session.
- $150 ($25 discount) if paid in cash.

For more rate information, call IHW at (218) 444-3161 or email us at contactus@getintegrative.com

INSURANCE

Jodi Anderson is licensed to provide therapeutic services by the State of Minnesota as a Licensed Independent Clinical Social Worker (LICSW). She is eligible to provide coverage through Blue Cross Blue Shield of MN, Medicaid (MA), Prime West. Although she does not work directly with other health insurance companies, many providers reimburse for services on an out-of-network basis. Coverage depends on your specific plan. Please see below for questions to ask your provider.

If you would like to use this option, **you will pay the full session fee at the time of service and submit the claim to your insurance company.** Please discuss this option with us so we can provide you with the appropriate forms and receipts.

As a general rule, health insurance companies will only pay for therapy if there is a diagnosable condition (e.g.: Dysthymic Disorder, Major Depressive Disorder, PTSD, Generalized Anxiety Disorder, etc.). In-network therapists must make a diagnosis within two sessions and submit details of the diagnosis, the current symptoms and a treatment plan to the insurance provider. Insurance companies who are paying for treatment have the right to periodically review progress and ask about any shifts in treatment-focus to determine whether they will continue to pay for therapy. Please note that couples therapy – where the relationship is the focus of the therapy – is NOT typically covered by insurance unless one of the parties has a diagnosable condition for which couples therapy is a legitimate and recognized treatment.
Mental health insurance coverage is changing. Many insurance companies are challenging the medical necessity of treatment. Those companies are asking for more reports (documentation) and are taking longer to respond to a claim. If it is necessary for us to prepare a report for an insurance company, you may be charged for report writing time at the same rate as therapy time.

Therapists who choose not to be in-network with health insurance companies still assess for diagnosable conditions, create treatment plans and keep regular progress notes. However, you *do not* have to meet criteria for a formal diagnosis to receive therapy, and you have much more flexibility in choosing the issues that you would like to be the focus of therapy. This means that you can bring any issues to therapy, whether it is relational, sexual, spiritual, cultural, work/career-related, bereavement-related or other areas of concern to you.

INSURANCE QUESTIONS TO ASK YOUR PROVIDER (CIRCLE THE RIGHT AMSWER)

- Do I have mental health insurance benefits? YES NO
- What is my deductible and has it been met? YES NO
- Do I have a co-pay and/or co-insurance? What is the amount? YES NO
- How many sessions per year does my health insurance cover? YES NO
- What is the coverage amount per therapy session? YES NO
- Do you require prior authorization before treatment begins? YES NO
- What forms do I need and where can I get them? YES NO

For more billing information, call IHW at (218) 444-3161 or email us at contactus@getintegrative.com

Adolescent Checklist of Concerns

Name: _____ Date ____/ _____/ _____

Age: _____ Person completing this form: _____ Relationship: _____

Many concerns can apply to both children and adults. If you have brought a child for evaluation or treatment, first please mark all of the items that apply to your child on the "Adult Checklist of Concerns." Then review this checklist, which contains concerns (as well as positive traits) that apply mostly to children, and mark any items that describe your child. Feel free to add any others at the end under "Any other characteristics."

- ❑ Affectionate
- ❑ Argues, "talks back," smart-alecky, defiant
- ❑ Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
- ❑ Cheats
- ❑ Cruel to animals
- ❑ Concern for others
- ❑ Conflicts with parents over rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
- ❑ Complains
- ❑ Cries easily, feelings are easily hurt
- ❑ Dawdles, procrastinates, wastes time
- ❑ Difficulties with parent's paramour/new marriage/new family
- ❑ Dependent, immature
- ❑ Developmental delays
- ❑ Disrupts family activities
- ❑ Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
- ❑ Distractible, inattentive, poor concentration, daydreams, slow to respond
- ❑ Dropping out of school
- ❑ Drug or alcohol use
- ❑ Eating—poor manners, refuses, appetite increase or decrease, odd combinations, overeats
- ❑ Exercise problems
- ❑ Extracurricular activities interfere with academics
- ❑ Failure in school
- ❑ Fearful
- ❑ Fighting, hitting, violent, aggressive, hostile, threatens, destructive
- ❑ Fire setting
- ❑ Friendly, outgoing, social
- ❑ Hypochondriac, always complains of feeling sick
- ❑ Immature, "clowns around," has only younger playmates
- ❑ Imaginary playmates, fantasy
- ❑ Independent
- ❑ Interrupts, talks out, yells
- ❑ Lacks organization, unprepared
- ❑ Lacks respect for authority, insults, dares, provokes, manipulates
- ❑ Learning disability
- ❑ Legal difficulties—truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
- ❑ Likes to be alone, withdraws, isolates

- ❑ Lying
- ❑ Low frustration tolerance, irritability
- ❑ Mental retardation
- ❑ Moody
- ❑ Mute, refuses to speak
- ❑ Nail biting
- ❑ Nervous
- ❑ Nightmares
- ❑ Need for high degree of supervision at home over play/chores/schedule
- ❑ Obedient
- ❑ Obesity
- ❑ Overactive, restless, hyperactive, out-of-seat behaviors, restlessness, fidgety, noisiness
- ❑ Oppositional, resists, refuses, does not comply, negativism
- ❑ Prejudiced, bigoted, insulting, name calling, intolerant
- ❑ Pouts
- ❑ Recent move, new school, loss of friends
- ❑ Relationships with brothers/sisters or friends/peers are poor—competition, fights, teasing/provoking, assaults
- ❑ Responsible
- ❑ Rocking or other repetitive movements
- ❑ Runs away
- ❑ Sad, unhappy
- ❑ Self-harming behaviors—biting or hitting self, head banging, scratching self
- ❑ Speech difficulties
- ❑ Sexual—sexual preoccupation, public masturbation, inappropriate sexual behaviors
- ❑ Shy, timid
- ❑ Stubborn
- ❑ Suicide talk or attempt
- ❑ Swearing, blasphemes, bathroom language, foul language
- ❑ Temper tantrums, rages
- ❑ Thumb sucking, finger sucking, hair chewing
- ❑ Tics—involuntary rapid movements, noises, or word productions
- ❑ Teased, picked on, victimized, bullied
- ❑ Truant, school avoiding
- ❑ Underactive, slow-moving or slow-responding, lethargic
- ❑ Uncoordinated, accident-prone
- ❑ Wetting or soiling the bed or clothes
- ❑ Work problems, employment, workaholism/overworking, can't keep a job

Any other characteristics: _____

_____

_____

Please look back over the concerns you have checked off and choose the one that you most want your child to be helped with and circle it.

Young Adult Information Form

Note: Unless there is a serious risk of injury to you or someone else, the information on this form is confidential. It will not be discussed with your parents without your consent.

Your name: _____ Nickname? _____

Today's date: _____ Your age: _____ Your phone #: _____

Your address: _____

Health

How tall are you? ___ ____ What do you consider your ideal weight? _____ Has your weight changed more than 10 pounds in the last year? ❑ No ❑ Yes How much? _____ Why? _____

What physical or medical problems do you have now, or have you had in the past? _____

_____

Family

Birth parents' names: _____ and _____

Address: _____ Phone # _____

Present parents'/guardians' names: _____ and _____

Address: _____ Phone # _____

How would you describe your parents' relationship? _____

What kinds of problems are you having with:

Parents/stepparents/guardians?

Parents' live-in friends or boyfriends/girlfriends?

Brothers or sisters (or stepbrothers or stepsisters)?

School

Which school do you go to? _____ Grade level/year: _____

How are your grades? _____

Problems in school? _____

_____

Work

Do you work? ❑ No If so, How many hours a week? _____ What do you do? _____

Problems there? _____

Friends

Who are your close friends (names and ages)?

Do you have a serious one-on-one relationship now? ❑ No ❑ Yes

Do you party? _____ If so, when and where? _____

Previous counseling

1. With whom? _____ When? _____

For what? _____

With what results? _____

2. With whom? _____ When? _____

For what? _____

With what results? _____

Concerns

Would you like information or answers on: ❑Sex (of any kind) ❑Birth control ❑Alcohol ❑Drugs

❑ Relationships ❑ Other concerns: _____

How important is religion to you and/or your family? _____ If so, in what ways? _____

_____

What worries or upsets you? _____

What makes you happy?

Why do you think you are here? Please tell me in your own words.

What would you like to see happen or change because of this counseling?

What would you like me to let your parents know?

What else is important for me to know?

What would you like me to ask you about?

Client's Signature: _____ Date ____/ _____/ _____

Adolescent Developmental History Record

A. Identifications

1. Child's name: _____ Birthdate: ____/ _____/ _____Age: _____

Person(s) completing this form: _____ Today's date: _____

2. Mother's name: _____ Birthdate: _____Home phone: _____

Address: _____

Currently employed: ❑ No ❑ Yes, as: _____ Work phone: _____

3. Father's name: _____ Birthdate: _____Home phone: _____

Address: _____

Currently employed: ❑No ❑Yes, as: _____ Work phone: _____

4. Parents are currently ❑Married ❑Divorced ❑Remarried ❑Never married ❑Other: _____

Child's custodian/guardian is: _____

5. Stepparent's name: _____ Birthdate: _____ Home phone:_____

Address: _____

Currently employed: ❑No ❑Yes, as: _____ Work phone: (_____)_____-_____

6. Other adult family members? _____

_____

B. Development

Please fill in any information you have on the areas listed below.

1. Pregnancy and delivery

   Prenatal medical illnesses and health care: _____

   _____

   _____

Was the child premature? ❑ No ❑ Yes. Weight and height at birth: _____ pounds _____ inches

Any birth complications or problems? _____

_____

2. The first few months of life

Breast-fed? If so, for how long? Any allergies? _____

_____

_____

_____

Sleep patterns or problems: _____

_____

_____

Personality: _____

_____

_____

_____

3. Milestones: At what age did this child do each of these?

Sat without support: _____ Crawled: _____ Walked without holding on: _____

Helped when being dressed: _____ Tied shoelaces: _____ Buttoned buttons: _____

Ate with a fork: _____

Stayed dry all day: _____ Didn't soil his or her pants: _____ Stayed dry all night: _____

4. Speech/language development

Age when child said first word understandable to a stranger: _____

Age when child said first sentence understandable to a stranger: _____

Any speech, hearing, or language difficulties? _____

_____

C. Health

List all childhood illnesses, hospitalizations, medications, allergies, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Consequences?

D. Residences

1. Homes

Dates					
From	To	Location	With whom	Reason for moving	Any problems?

2. Residential placements, institutional placements, or foster care

Dates				
From	to	Program name or location	Reason for placement	Problems?

E. Schools

School (name, district, address, phone) Grade Age Teacher

May I call and discuss your child with the current teacher? ❑ Yes ❑ No

F. Special skills or talents of child

List hobbies, sports; recreational, musical, TV, and toy preferences; etc.: _____

_____

_____

_____

_____

G. Other

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?

_____

_____

_____

_____

_____

Name: _____ Date ____/ _____/ ____

PHQ-9

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
		PHQ9 total score:			

Q6 CORE 10	I made plans to end my life in the last 2 weeks	NO	YES

GAD-7

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
		GAD7 total score:			