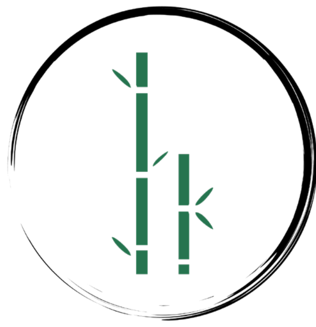

ABHA
ADVANCED BEHAVIORAL HEALTH ANALYSIS LLC

CHILD & ADOLESCENT INTAKE QUESTIONNAIRE

Confidential

The following questionnaire is to be completed by the child's parent or legal guardian. This form has been designed to provide essential information before your initial appointment to make the most productive and efficient use of our time. Please feel free to add any additional information which youthink may be helpful in understanding your child. Information provided by you is strictly confidential and will only be released in accordance with HIPPA guidelines and as mandated by law. Please use the backsof the pages for additional information.

PLEASE PRINT

Name of Person Completing this form: ______________________________

Legal Name of Child/Adolescent: ______________________________

Nickname or name child routinely goes by: ______________________________

Child's Date of Birth: ______________________ Age: __________

Home Address: ______________________________

Street City County State Zip

Home Telephone Number:

Phone(s) Mother: ______________

Father: ______________

Cellular Phone(s) Mother: ______________

Father: ______________ Sponsor's Rank: ________

School Name: ______________________ System: ______________ Grade:

School Telephone Number: ______________________________

Current Teacher(s): ______________________________

Who referred you to our practice? ______________________________

Please describe the problems your child is now having, and what type of services you are seeking fromus for these problems. Please use the back of this page for additional space.

INDICATE PARRENT/GUARDIANS LIVING IN THE HOME:

Marital Status: Married – Remarried – Divorced – Separated – Widowed – Single – Cohabitants

- ☐ If divorced, who has physical custody? ____________________ Is it full or joint? __________
- ☐ Who has legal custody?_________________Is it full or joint? _________________________
- ☐ If divorced, please provide a copy of the custody agreement.

Mother's Name:_______________________________________Rank: ______________________

Date of Birth _________________________________ Age _______ ______

Occupation: _________________________SSN: _____________________

Employer:_________________________________email: ________________________________

Education Completed______________________Health:____Excellent____Good____Fair____Poor

Father's Name____Rank: ______________________

Date of Birth: _________________________ Age: ____________

Occupation: _________________________SSN: _____________________

Employer:_________________________________email: ________________________________

Education Completed_____________________Health:_____Excellent____Good____Fair____Poor

Does either parent's job require him/her to be away from home long hours or extended periods?

____

If YES, how often? ____

Siblings:

Name	Age	Relationship	Living in	School	Grade
____________	______	_____________	Y/N	__________	______
____________	______	_____________	Y/N	__________	_______
____________	______	_____________	Y/N	__________	_______

Please list additional Siblings in the above format on this page.

PSYCHOLOGICAL HISTORY:

Is there a history in your immediate or in the mother's or father's extended family, or the followingand if so who?

Yes	No		Who
____	____	Autism Spectrum Disorders	______________________
____	____	Learning Problem/Disabilities	______________________
____	____	ADHD – ADD --- Attention Problems	______________________
____	____	Depression & Manic --- Depression	______________________
____	____	Behavior Problems in School	______________________
____	____	Anxiety Disorders (OCD, Phobias, etc.)	______________________
____	____	Mental Retardation	______________________
____	____	Psychosis/Schizophrenia	______________________
____	____	Substance Abuse/Dependence	______________________
____	____	Other Mental Health Concern (Please List)	______________________

Has the child you are seeking services for been evaluated in the past? Yes/NoIf Yes,

please list the following information on the previous evaluation(s)

Who	Type	When	Copy Available
________________	________________	________________	Y/N
________________	________________	________________	Y/N
________________	________________	________________	Y/N
________________	________________	________________	Y/N

(If more evaluations need to be listed please use the space on the back of this page.)If yes,

what were their general findings and recommendations?

____

____

____

Please provide us with any other information on the psychological history that you feel would behelpful to us in understanding your

child ________________ ____

____

____

PRE---NATAL AND DELIVER HISTORY:

Were there any complications with the Pregnancy? Y/N

____

If Yes, please provide treatment details:

____

____

____

Was birth at Full Term? Y/NIf

No, please provide detail:

____

____

Type of Delivery: Spontaneous/Induced Vaginal/C---Section

Complications? Y/N

If Yes, Please provide details:

____

____

Birth Weight:__________lbs.__________oz. Apgar Scores: ___________ _________

Concerns at Birth? Y/N

If Yes, please provide detail – including any treatments given (Additional space on back if needed):

____

____

Is there any additional pre---natal or birth information that might be of assistance to us?

____

____

DEVELOPMENTAL HISTORY:

1. Please indicate the age at which your child did the following:

Rolled over consistently	__________	Said two---three word phrases	________
Sat up unsupported	__________	Used Sentences regularly	_________
Stood	__________	Toilet trained during the day	_________

Crawled __________ | Dry through the night (6+ months) ______

Walked Unassisted __________ | Dressed Self ________

Said 1st Word Intelligible to strangers _______

2. Please indicate if your child is experiencing any of the following:
   - Problems with eating ____________
   - Isolated socially from peers ____________
   - Problems making friends ____________
   - Problems keeping friends ____________
   - Problems getting to sleep ____________
   - Problems controlling temper ____________
   - Nightmares ___________
   - Bed Wetting/Soiling ____________
   - Problems with Authority ____________
   - Anxiety ____________
   - Unmotivated ____________
   - School concentration difficulties ____________
   - Grades dropping or consistently low ____________
   - Sadness or Depression ____________

3. List any operation, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child has had.

   ____

   ____

   ____

4. List any medications your child is currently taking or has taken for extended periods (givedosage level if possible):

   ____

   ____

   ____

5. Child's current height:________Ft.______Inches Weight:_______lbs.

6. With which hand does the child write: ____

7. Does the child have any vision problems? ________________________________

8. Please list date of last vision test and who performed (pediatrician, optometrist, School)

____

____

9. Does the child have any hearing problems? ___________________________________

Please list date of last hearing test and who performed (pediatrician, optometrist, School)

____

____

10. Name of child's physician(s) ____

Practice Name: ____

Address: ____

____

Phone Number:____________________________Fax Number: _______________________

(Please list information on additional Physicians on the back of the page)

EDUCATION HISTORY:

1. List in chronological order all schools your child has attended:

Name	System	Year(s)	Grade	Special Ed

2. Name(s) of current teacher(s) ____
3. Does your child's teacher have concerns about him/her (list)

____

____

4. What is your child's favorite subject/class? ______________________________________
5. What is your child's least preferred subject/class? _________________________________
6. Has your child ever repeated a grade? Y/N If yes, what grade (s)?: __________________________
7. If your child has been in Special Education, did they have a:

- ☐ 504 Plan
- ☐ I.E.P.
- ☐ Psychological Evaluation
- ☐ Special Evaluation
- ☐ Behavior Intervention Plan
- ☐ Occupational Therapy Evaluation
- ☐ Physical Therapy Evaluation
- ☐ Adaptive Technology Evaluation

8. If your child has been in Special Education, how were they served?

- ☐ Consultation
- ☐ Resource Classroom
- ☐ Collaborative Education
- ☐ Team Taught Classes
- ☐ Pull---Out
- ☐ Self---Contained Classroom
- ☐ Special Program
- ☐ Psycho educational Center

9. Chile's extracurricular activities, including sports, clubs, hobbies, lessons, etc.:

______ Football ______ Karate ____Dance (type) ________________

______ Baseball ______ Piano _____Music (type) _______________________

______ Cheerleading ______ Scouts ______ Gymnastics (type)_________________

______ Basketball _____ Soccer ______ Other(s): __________________________

10. List any special abilities, skills, strengths your child has:

____

____

____

DISCIPLINE INFORMATION

Parents may use a wide range of discipline strategies with their children. Listed below are severalexamples. Please rate how likely you are to use each of the strategies listed:

Intervention	Very Unlikely				Very Likely	Effectiveness	
Let situation go	1	2	3	4	5	________ ________	________ ________
Take away a privilege (ex., no TV)	1	2	3	4	5	________	________
Assign an additional chore	1	2	3	4	5	________	________
Take away something material	1	2	3	4	5	________	________
Send to room	1	2	3	4	5	________	________
Physical punishment	1	2	3	4	5	________	________
Reason with child	1	2	3	4	5	________	________
Ground child	1	2	3	4	5	________	________
Yell at child	1	2	3	4	5	________	________
Send to time out	1	2	3	4	5	________	________
List anything else you may do:							
______________________	1	2	3	4	5	________	________

Go back and rate the THREE MOST effective strategies. That is, place a 1 by the most effective, a 2 bythe next most effective, and a 3 by the third most effective. Please circle the LEAST effective. Please rate what percentage of discipline is handled by each of the following:

Father:______% Mother:_____% Other:_______% (Please Specify:)________________________________

GENERAL INFORMATION:

Please list the **five** things you would like for your child to do more of and less of in order of priority toyou. For example, instead of saying, “I want my child to be more responsible,” translate that into actual behaviors such as do household chores, care for brothers and sister, etc.

	Like Child to do More Often	Like Child to do Less Often
1.	______________________________	______________________________
2.	______________________________	______________________________
3.	______________________________	______________________________
4.	______________________________	______________________________
5.	______________________________	______________________________

INFORMED CONSENT FOR BEHAVIORAL SERVICES:

I hereby voluntarily apply for and consent to services by Onward Momentum LLC. This consent applies to myself, ward, or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent. I understandand agree that my disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information, or under certain other conditions listed below: (1) where abuse or harmful neglect of children, the elderly, or disabled or incompetent individual is known or reasonably suspected: (2) where such information is necessary for the company to pursue payment for services rendered; (3) where an immediate threat of physical violence against a readily identifiable victim is disclosed to the therapist; (4)where the client is examined pursuant to a court order. I hold Onward Momentum LLC harmless for releasing information under the above conditions.

____ ______________________________

Signature Date

____ ______________________________

Printed Name Name of Client

ABHA

ADVANCED BEHAVIORAL HEALTH ANALYSIS LLC

ADVANCED BEHAVIORAL HEALTH ANALYSIS

CLIENT DEMOGRAPHIC AND INFORMED CONSENT

NAME: ____ DATE: __________________

SSN: ________________________ DOB: _______________ AGE: _______ GENDER: _______

ADDRESS: ____

CITY: ____ZIP:___________________

HOME: ______________________ WORK: ___________________ CELL: ___________________

MAY WE LEAVE MESSAGES AT ABOVE LISTED NUMBERS? ________ YES _______ NO

EMAIL: ____

MAY WE CONTACT YOU AT THIS EMAIL? _______ YES _______ NO

<u>RESPONSIBLE PARTY/SUBSCRIBER INFORMATION</u>

GUARANTOR NAME: ____ DOB: _________

GENDER: ________ SSN: ______________________ MARITAL STATUS: _________________

ADDRESS: ____

CITY: ____ZIP:___________________

NAME AND NUMBER OF EMERGENCY CONTACT PERSON: ___________________________

HOW DID YOU HEAR ABOUT ABHA?

____

____

____

____

BRIEFLY DESCRIBE THE ISSUES/PROBLEMS THAT LED YOU TO SEEK THERAPY TODAY:

____

____

____

____

Insurance Information – Please Fill out COMPLETELY

Primary Insurance: ______________________________ Policy Number: ___________________

SecondaryInsurance: ____________________________ Policy Number: ___________________

Do you know of any co-pay or cost share amounts? ________YES ________NO

If Tricare, is the sponsor: □ active duty □ retired □ guard/reserve

Out-Of-Network Insurance Statement

I am aware that my insurance,________________, is NOT contracted with ABHA. I also understand that there will be NO contractual adjustment made on my account, as there would normally be for In-Network Providers. I understand that in addition to any co-insurance, copayments or deductibles applied by my insurance, I am FULLY responsible for the difference in what ABHA charges for services rendered and what my insurance allows for those same charges.

I understand the above statement. Any questions I have regarding my insurance benefits have been asked and answered to my satisfaction. I choose to seek treatment with ABHA LLC.

Guarantor's Signature: ______________________________________ Date: __________________

Guarantor's Printed Name: ____

Non-Coverage of Services Statement

I understand that according to the benefits quoted by my insurance company to Advanced Behavioral Health Analysis may NOT be a payable service due to diagnosis conflicts, refusal of referral, refusal of authorization, etc. If I still choose to seek treatment through Advanced Behavioral Health Analysis LLC, I understand that I will be FULLY liable for the financial obligations of services rendered if my insurance company denies the charges.

Guarantor's Signature: ____ Date: __________________

Guarantor's Printed Name: ____

INFORMED CONSENT FOR TREATMENT

The following information is provided to inform you of what to expect from the counseling services at Advanced Behavioral Health Analysis. and to ensure that you understand the professional relationship between you and your counselor. In order to receive treatment, your signed consent is necessary.

Counseling Process

Counseling presents an opportunity to make an investment in your personal growth and well- being within the context of a professional, helping relationship. Initially, your counselor will take a personal history and explore your reasons for seeking counseling at this time. The counselor will then assist you in creating a treatment plan and clarifying your goals. Your commitment and personal involvement are vital to the counseling process and in order to find the best results, you will be encouraged to focus on your goals in between sessions and be willing to try new behaviors and skills. Periodically, a review and evaluation of your progress will be addressed, and your treatment goals will be revised as needed. If you are signing this consent on behalf of your child, both you and the child are required to be involved in the process.

Counseling Benefits and Risks

Please note that participating in counseling offers both risks and benefits. Counseling often addresses difficult aspects of life experience and it may cause you to experience more intense or uncomfortable feelings, like sadness, shame, guilt, and even anxiety. This occurrence is expected and usually will only last a short time. In the long run, however, research has consistently revealed the benefits of counseling and Advanced Behavioral Health Analysis. is committed to employing evidence-based

therapies to provide you the best quality care. While there are no guarantees, counseling often leads to a better quality of life overall, including for example, improved self- concept, better relationships, and more effective management of emotions.

Continuation and Maintenance of Treatment

One of the primary treatment goals of Advanced Behavioral Health Analysis. is to lessen the need for treatment. Ideally, as you improve, the frequency of your sessions will start to decrease to a maintenance phase where you will need less and less counseling, and then you may come only as needed.

Continuation and Maintenance of Treatment

One of the primary treatment goals of Advanced Behavioral Health Analysis. is to lessen the need for treatment. Ideally, as you improve, the frequency of your sessions will start to decrease to a maintenance phase where you will need less and less counseling, and then you may come only as needed.

Explanation of Dual Relationships

While a healthy counseling relationship is at times very personal and intimate in nature, it is important to be clear that your relationship or your child's relationship with your counselor is a professional one. Our counselors hold their role in the highest esteem and believe the safety of the therapeutic relationship to be a vital part of the process of healing and growing. Professional boundaries will be maintained at all times. We will respect your privacy in public and will not speak to you or acknowledge you unless you choose to speak to us.

Confidentiality

The relationship between client and counselor is confidential and protected legally and ethically. Advanced Behavioral Health Analysis adheres to the American Counseling Association's ethical guidelines, which can be found at http://counseling.org/Resources/aca- code-ofethics.pdf. The confidential information in your file is used within Advanced Behavioral Health Analysis to provide treatment and every effort is made to keep it protected and secure. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Some noted exceptions include: 1) the duty to warn and protect a client in danger of harming him/herself or another person; 2) when there is suspected child or elder abuse or neglect; 3) in the case of a court order or legal matter; and 4) in consultation and/or supervision. Please see the HIPAA form attached for the detailed regulations regarding confidentiality.

Length of Sessions

Sessions normally last 45-50 minutes. Typically, our counselors see clients for one 45-50-minute session per week, unless it is decided that there is a higher need. In that case, they may recommend meeting more than once a week. If you arrive late for your session, it will still end at the scheduled time. If you arrive later than 15 minutes after your scheduled time, our counselors have the right to cancel the session.

Please understand that we will do our absolute best to run on time and we usually are punctual, though crises do occur, and sessions may be extended if required. If we are running behind for some reason, we will still honor the full 50 minutes of your session.

Fee and Method of Payment

Advanced Behavioral Health Analysis accepts cash and checks. You are expected to pay-in-full at the time of your session unless prior arrangements have been made. Please be prepared with your check pre-written ready to pay at the beginning of each session so that the majority of the session can focus on your clinical needs. Also, if you pay by cash, please have the proper amount because Advanced Behavioral Health Analysis does not have cash on hand to provide change.

Upon setting up your initial appointment, please let us know if you will need a monthly statement or a receipt for insurance reimbursement. If you are paying by insurance, fees may vary and our office manager will discuss this with you as appropriate.

In Case of an Emergency

Counselors of Advanced Behavioral Health Analysis do not provide emergency services. We will make every attempt to be available to you as soon as possible should a crisis occur. If you cannot wait for our return call, please call 911 or go to the nearest hospital and we will attempt to contact you as soon as possible. Otherwise, you may leave a message on the main number for Advanced Behavioral Health Analysis at (850) 301-0438. Please note that though our counselors cannot often answer the phone directly because they are in session, we do have a receptionist and additional administrative support and we check our messages frequently and will call you back as soon as possible.

Cancellation Policy

If you need to cancel a therapy session, you must notify Advanced Behavioral Health Analysis 24 hours before the scheduled counseling session. You may leave a message at **(850) 374 - 3991**. This consideration helps us accommodate all families considering scheduling and availability.

Our policy states that we will charge you $40.00 after 2 consecutively missed appointments without proper notification and the fee will not be covered by insurance.

Sick/Illness Policy

This facility is a well-client facility. This means that if you or your child are not feeling well, for any reason, you will need to reschedule your therapy appointment. Please do not bring your child if he/she has a contagious illness or exhibits any of the following symptoms: fever above 100 degrees Fahrenheit in the last 24 hours, vomiting in the last 24 hours, diarrhea, conjunctivitis (pink eye), consistent complaints of ear or stomach pain, bleeding other than minor cuts and scrapes, greenish nasal discharge, indicating possible infection, or head lice. In general, if your child is too sick to go outside and play, then your child is too sick to attend therapy. We use play as a part of therapy and sickness or illness is not conducive to therapy.

Legal Involvement

Counselors at Advanced Behavioral Health Analysis reserve the right to deny involvement in any court case or legal proceeding. If we are required to share information due to a court order, we will only provide the client's dates of treatment and a brief summary of services. If you have any questions or concerns about this Informed Consent for Treatment, the HIPAA policy or insurance information, please discuss them with our office manager or your counselor in your initial appointment and whenever necessary. Please sign to show that you received this form and agree with the terms. You may request this form for your records.

With my signature below, I acknowledge that I have read, understand, and agree to all of the above. I also acknowledge that I have been given a copy of HIPAA/Privacy Practices implemented here at Advanced Behavioral Health Analysis.

____ __________________

Signature of Client or Legal Guardian Date

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This information is effective as of January 2019.

CONFIDENTIALITY

Federal and State laws protect your confidentiality (See 42 U.S.C. 290dd-3 and 290ee-3 for Federal laws and 42 CFR Part 2, 491.0147 FL). Your counselor will not share information with any person outside of Advanced Behavioral Health Analysis. without your permission, except as required by law or needed to file your insurance claim.

Information obtained by minors is not generally shared with parents without permission. Exceptions to confidentiality: Federal regulations do not protect from disclosure of information related to a client's involvement in a crime against property or personnel. We are required under State law to report suspected abuse of a child, elderly person, or individual with a disability, or any reported sexual misconduct by a licensed health care provider. We may share limited information in the event of a medical emergency or in the event of a specialized court order signed by a judge. Your counselor has the option of breeching confidentiality if you report a specific plan or intent to cause serious bodily harm to an identifiable person. HIPAA (Health Insurance Portability and Accountability Act) laws allow you access to your file and protect the electronic transfer of information.

This notice describes our polices related to the use and disclosure of the client's healthcare information. Use and disclosure of protected health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.