THE PSYCHIATRY & PSYCHOLOGY CENTER
650 GRISWOLD ST., NORTHVILLE, MI 48167
PHONE (248) 912-0080
FAX (248) 912-0208

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**Child & Adolescent Psychosocial Questionnaire**

(Ages 1-17)

In order to better serve you, we would like you to **FULLY** complete this questionnaire and return it to the receptionist as soon as it is complete. Please ensure that no question is left blank. This information is kept strictly **confidential** as required by State and Federal guidelines.

Date: ______________

Name: ____________________________________________________________________________

Parent/Guardian Name:______________________________________________________________

Child's D.O.B:_______________________________

Primary Care Physician:_____________________________________ Phone:__________________________

Why have you decided to come into treatment now?

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________

What would you like to accomplish by coming today?

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________

Please indicate whether this child is experiencing any of the following:

**( ) suicidal ideas/expression ( ) homicidal ideas/expression ( ) none**

Please explain:__________________________________________________________________________

Please indicate whether this child has a history of any of the following:

**( ) suicidal ideas/expression ( ) homicidal ideas/expression ( ) none**

Please explain:___________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

**<u>In Case of Emergency, Contact:</u>**

Name: ____________________________________________________________________________

Relationship: ______________________________________________________________________

Address: __________________________________________________________________________

Cell Phone: ________________________________________________________________________

**Residence Situation:**
( ) lives with both parents ( ) joint custody arrangement ( ) lives with mother
( ) lives with father ( ) lives with grandparents ( ) other
**Family Composition:**
**Religion (Optional)** ( ) Catholic ( ) Protestant ( ) Jewish ( ) Hindu ( ) Other
How important is your child's Religious/Spiritual Beliefs:
( ) very important ( ) somewhat important ( ) not important
Would you like to talk to your therapist about your child's religious/spiritual beliefs? Yes / No
**Race (Optional)** ( ) Caucasian ( ) African-American ( ) Native American
( ) Hispanic ( ) Asian-American ( ) Other:______________________
Would you like to talk to your therapist about any racial/cultural issues? Yes / No
**Client's Behavioral Health Treatment History:**
Has your child ever seen a behavioral health care provider before? Yes / No
If yes inpatient or outpatient? ______________________________
If yes for Inpatient, Name of Facility: ________________________________________________________
Address: ________________________________________________________________________________
Length of Stay: _______________________________
Number of admissions: _________________________
If yes for Outpatient, Name of Facility: ______________________________________________________
Address: ________________________________________________________________________________
Name of Therapist: ____________________________ Phone#: __________________________________
What type of therapist were they? ( ) Psychiatrist ( ) Psychologist ( ) Social Worker
( ) Other:____________
When did your child see therapist and for what reason:
_____________________________________________________________________________________
_____________________________________________________________________________________
**Medication History:**
What medication do you know your child should not take?_____________________________________
What medication do you know your child should not stop taking?______________________________
What herbal remedies is your child currently taking?_________________________________________
Please list all medications this child is **currently** on or has taken in the **last year** (prescription and over-the-counter):
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
Who has been prescribing the medications listed above?
Name: __________________________________________________________________________________
Address:_________________________________________________________________________________
Telephone No.: ___________________________________________________________________________
**Current General Health Status:**
Please describe your child's current general health:
( ) Excellent ( ) Very Good ( ) Good ( ) Fair ( ) Poor ( ) Very Poor
Is your child feeling any physical pain at this time? Yes / No
If yes please explain: _______________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**Nutritional Screening:**
Has your child **gained weight** or **lost weight** in the last 30-60 days? Yes / No
If yes, how much and why?
Do you have any diet or nutritional concerns about your child? Yes / No
If yes, please explain:
Does your child have any food or medication allergies? Yes / No
If yes, please list:

____________________________________________________________________

____________________________________________________________________

**Substance Use:**
Does your child use Nicotine? Yes / No
If yes, ( ) Cigarettes/Cigars/Pipe ( ) Chewing tobacco
Amount per day:__________ How long have they used?______________________
Any related health Problems?_____________________________________________________________
Does your child use Alcohol? Yes / No
If yes, How often do they use?___________ How long have they used?_________________
How much do they usually drink?_____________________
Any related health issues?______________
If any Recovery, Longest length of Sobriety:________________
Does your child use any Illegal Drugs? Yes / No
If yes, What drug (s) do they use?____________________________
How often do they use?____________________________________
How much do they use?___________
When was the last time they used?____________

**Developmental History:**
Duration of Pregnancy:_________________________________________________________________
Smoking during pregnancy Yes / No
If yes, number of cigarettes daily:_____________
Alcohol during pregnancy Yes / No
If yes, amount and type:________________________________________________________________
Drugs during pregnancy Yes / No
If yes, please explain:
Medications during pregnancy Yes / No
If yes, please explain:
Complications during pregnancy? Yes / No
What type?:______________________________________________________________

**Delivery**
Was the labor and delivery of your child normal? Yes / No
If No, Please explain:

____________________________________________________________________

____________________________________________________________________

Birth Weight ______lbs. ______________________
Infant days in the Hospital:_______________
APGAR (if known)_____________________

**Milestones:**
Please indicate and describe if you child has had any problems with **motor skills**, **language**, or **social attachment**: If yes, please specify which area and what happened:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

**Medical:**
Do you feel your child needs a physical exam? Yes / No
When was the last time your child had a physical exam?________________________________________
Has your child suffered from any **childhood illnesses/disorders, operations**, and/or **hospitalizations** (please include dates and ages)
If yes, please explain:
Head Injuries: ( ) without loss of consciousness
( ) with loss of consciousness
Please explain:________________________________________________________________________
Convulsions: ( ) without fever ( ) with fever
Please explain:________________________________________________________________________
______________________________________________________________________________________

**Abuse:**
Has your child ever experienced any:
( ) Physical Abuse ( ) Sexual Abuse
( ) Emotional Abuse ( ) Abandonment/Neglect
If yes, by whom:______________________________________________________________________
Length/Duration of abuse:_________________________________________________________________
Age of child:
Was it reported to the authorities: Yes / No
Please explain:________________________________________________________________________
Has your child ever witnessed abuse:
( ) Physical Abuse ( ) Sexual Abuse
( ) Emotional Abuse Has your child ever inflicted abuse on another person:
Physical abuse: Yes / No
Sexual abuse: Yes / No
Emotional abuse: Yes / No

**Family Social History:**
Name of child's mother:_______________________________________ Age of mother:_____________
Level of Education:_____________________________________________________________________
Name of child's father:______________________________________________ Age of father: ________
Level of Education:_____________________________________________________________________
Biological parents are: ( ) married ( ) separated ( ) divorced ( ) other:___________________
How would you describe the relationship between your child and his/her siblings?:
( ) Excellent ( ) Good ( ) Fair ( ) Poor
Please explain:_____________________________________________________________________

**Family History:**
Please indicate **any family history** of the following:
( ) Substance Abuse: If yes, indicate who:______________________________________
( ) Mental Illness: If yes, indicate who:__________________________________________
( ) Suicide: If yes, indicate who:_________________________________________________
( ) Autism: If yes, indicate who:_________________________________________________
( ) Developmental Disability, if yes who:_________________________________________
( ) ADHD: if yes, who:_______________________________________________________

**Social History:**
Please indicate if you have the following concerns regarding your child:
( )Peer Relationships
( )Gang Involvement
( ) Relationship with Authority
( ) Social Support Networks
( )Hobbies/Interest
Please list your child's hobbies and leisure activities: ___________________________________________
What are the main strengths of your child?
_____________________________________________________________________________________
_____________________________________________________________________________________

**Education:**
What grade is your child currently in:
Child Attended:
( ) Infant day care ( ) pre-school ( ) kindergarten
Official School Classifications
( ) LD or ADHD ( ) ED ( ) MR
( ) Visually Impaired ( ) Hearing Impaired ( ) Other
Type of Placement:
( ) regular classes ( ) special education ( ) honors (T&G) ( ) home study
Please indicate if you have any concerns in the following areas:
( ) Adjustments
( ) Behavioral Problems
( ) Repeated grades
( ) Suspensions/Expulsions
( ) Performance/Achievements
( ) Attitude towards school
Name of School:
Address:
Telephone No.:______________________________________________________________________
Principal's Name:____________________________________________________________________
School Social Worker:________________________________________________________________

This certifies all of the information stated above is accurate and complete to the best of my abilities.

__________________________________ ____________________
Signature of Mental Health Professional Date

___________________________________ ______________________
Signature of Parent/Guardian Date

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# AGREEMENT FOR PSYCHIATRIC TREATMENT

Patient Name__________________________________________________________ Date of Birth______________________
(please print clearly)

Address: ____________________________________________________________________________________________

Home Phone#:_____________________________________ Cell Phone#: ______________________________________________

The purpose of this agreement is to give you information about the medications you will be taking and to assure that you and your provider complies with all state and federal regulations concerning the prescribing of controlled substances. The provider's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the provider/patient relationship and full agreement and understanding of the risks and benefits.

1. **You should use one** provider to prescribe and monitor your psychiatric medications.
2. You should use **one** pharmacy to obtain all prescriptions and adjunctive analgesics prescribed by your provider.
3. You should inform your provider of all medications you are taking, including herbal remedies, since medications can interact with over-the-counter medications and other prescribed medications.
4. You will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment, plus usually two to three days extra. This extra medication is **not** to be used without the explicit permission of the prescribing provider unless an emergency requires your appointment to be deferred one or two days.
5. Prescriptions will be done only during an office visit or during regular office hours. **No** refills of any medications will be done during the evening or on weekends.
6. You must bring back all medications and adjunctive medications prescribed by your provider in the original bottles.
7. If your account is delinquent and payments are not made timely, treatment will be terminated.
8. **You are responsible for keeping your medication in a safe and secure place**. You are expected to protect your medications from loss or theft. Stolen medications should be reported to the police and to your physician immediately. If your medications are lost, misplaced or stolen, your physician may choose not to replace the medications.

Medication:

1. I understand that the medication(s) being prescribed for treatment of symptoms of an emotional disorder. The use of the medication(s) at this time may benefit the conditions for which I/we seek treatment. I understand that there is no guarantee that this medication(s) will be beneficial.
2. I understand that arrangements will be made to monitor response to this medication(s) to assess its effectiveness, and it will be discontinued if it is no longer found to be necessary or effective. It will be prescribed in the dose, which is thought to be effective.
3. I understand that all medication(s) may produce side effects, and some side effects may be serious and permanent. I have received instructions regarding this medication(s) and its common and serious side effects. I understand the importance of reporting side effects and unusual reactions to provider.
4. I understand the use of this medication(s) and was given the opportunity to ask questions pertaining to the medication(s).
5. I have told the provider my medical conditions, current medications and history of reactions to medications to the best of my knowledge.
6. I understand the importance of taking this medication(s) per provider's instructions.
7. I consent voluntarily to the prescription of this medication(s) and understand that I may withdraw this consent without prejudice to further treatment.
8. The provider has discussed alternative treatment options (including no treatment).

I agree with above: ________________________________________ ____________________
Signature (patient/Guardian) Date

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Patient Name_____________________________________________ Date of Birth______________________
(please print clearly)

**Psychiatrist Communication Form**
**Primary Care Physician**
**Mental Healthcare Professional**

Consent to Exchange Information

**I,___________________________, authorize** THE PSYCHIATRY & PSYCHOLOGY CENTER

and ________________________________________________________________________________
(Primary Care Physician Name, Address & Phone Number)

and ________________________________________________________________________________
(Mental Healthcare Professional Name, Address & Phone Number)

to exchange information regarding my mental health/substance abuse treatment and medical healthcare for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care or substance abuse care and/or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect for one year from the date of my signature below or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral healthcare provider. I also understand that it is my responsibility to notify my behavioral healthcare provider if I choose to change my Primary Care Physician.

__________________________________________ __________________________
Signature (parent or guardian if patient is a minor) Date

________________________________________ _________________________
Signature (Provider) Date

**Robert Garcia, MD**
**Child, Adolescent &**
**Adult Psychiatrist**

**Robert Zoltowski, DO**
**Adult Psychiatrist**

**William Guy, MD**
**Adult Psychiatrist**

**Lauren Walters PA-C**
**Physician Assistant**

Patient Information

DSM IV Diagnosis and Code: __________________________________________________________________

Recommended Treatment:
________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

A COPY OF THIS FORM MUST BE SENT TO THE PRIMARY CARE PHYSICIAN, RETAINING THE ORIGINAL IN THE PATIENT'S CHART. IF THE FORM IS SENT BY FAX, ATTACH CONFIRMATION THAT FAX WAS SENT.

___________ _________________
DATE SENT RECEIVED BY (PCP OFFICE STAFF PLEASE INITIAL)

Please Check Method
Fax ☐ Mail ☐

Please file in Patient's chart

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# GENERAL CONSENT FOR TREATMENT
# (HIPPA)

I, the undersigned,

1. Voluntarily consent to treatment as recommended and fully explained to me by staff of The PSYCHIATRY & PSYCHOLOGYCenter and understand that I am free to withdraw my consent and discontinue treatment at any time.
2. Understand that I have rights as a recipient of counseling services, that I have received a description of my rights, and that I may receive additional information about my rights from the Recipient Rights Advisor identified to me.
3. Understand that the confidentiality of records maintained by The PSYCHIATRY & PSYCHOLOGY Center is protected by 42 CRF Part 2 Federal Regulation. Program staff may not disclose any identifying information to outside sources regarding a client's treatment unless the client gives consent. Program staff may release client information without client consent under the following specific conditions:
   - Client threatens to harm self or others;
   - Suspicion of child abuse or neglect;
   - Medical personnel, to meet a bona fide medical emergency when there is immediate threat;
   - Research activities and program evaluation. Personnel may not identify directly or indirectly any individual patient in any report or otherwise disclose patient identities in any manner.
   - Management and financial audits. Examiner must furnish to the program a written statement that no record will be made of patient identifying information unless notice is provided to the program, and, if necessary, setting forth the specific purpose for which identifying information is being retained, how it is to be retained and the contact person; or'
   - Authorized by court order under Sub Part E – Section 2.61 of 42 CFR Part 2.

   Violation of the Federal regulation is a crime. Suspected violations may be reports to appropriate authorities in accordance with Federal regulations. Federal regulations do not protect any information about a crime committed by a client either at the program or against any person who works for the program or about any threat to commit such a crime.
4. Acknowledge that any violent or hostile behavior will result in discharge. I understand that possession of a weapon on clinic property is prohibited. I understand that I will be refused a therapy appointment on any day that I come to my a appointment intoxicated. I understand and have been advised of additional program policies regarding conditions under which I may be discharged. I further understand that I have the right to appeal this action to the clinical manager within 15 days from which it occurs.
5. Understand I am to follow through to the best of my ability in developing and achieving treatment goals/objectives, as agreed upon by my therapist and myself. I understand that if I fail to follow through on significant parts of my treatment plan, possibly resulting in harm to myself or others, my therapist may choose to refer me to a more appropriate treatment setting.
6. PAYMENT FOR SERVICES AGREEMENT
   I understand that I have disclosed all information regarding my health insurance. I further acknowledge the insurance information to be accurate and complete. I accept the responsibility for my fees, co-pays, deductibles, charges in insurance, and for all services rendered to me. I authorize The PSYCHIATRY & PSYCHOLOGY Center to submit billing statements to my insurance carrier(s) for the purpose of receiving reimbursement for services until payment is received for all services provided to me. I further understand that I am responsible for the cost of my treatment, and that I will be billed directly if insurance claims are rejected or denied. Finally, I understand that established appointments are reserved for me, and that I may be subject to the usual and customary charge for late arrival, all appointments missed or canceled without 24 hour notice. (EXCEPTION – UNDER CMS GUIDELINES MEDICAID RECIPIENTS CANNOT BE CHARGED ANY FEES). BY SIGNING THIS FORM I ACKNOWLEDGE THAT I HAVE HAD THE OPPORTUNITY TO READ THIS FORM (OR HAVE IT READ TO ME), ASK QUESTIONS AND HAVE THESE QUESTIONS ANSWERED. ACKNOWLEDGE OF PRIVACY PRACTICES The PSYCHIATRY & PSYCHOLOGY Center Notice of Privacy Practices provides information about how protected health information About me (the patient) – including information about human immunodeficiency virus (HIV), AIDS-related complex (ARC); and acquired immunodeficiency syndrome (AIDS); and including substance abuse treatment records protected under the regulations in 42 Code of Federal Regulations, part 2, if any, and psychological and social services records, including communications made by me to a social worker or psychologist (if any) – may be used and disclosed. I have been offered an opportunity to review the Notice before signing this consent. I understand that the terms of the Notice that I may change and that I may obtain a revised copy by contacting the privacy officer listed in the Notice.I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment or health care operations. My physicians and the facility are not required to agree to this restriction,but if they agree, they will be bound by the agreement. By signing this form, I acknowledge that I have been offered and/or received the PSYCHIATRY & PSYCHOLOGY Center Health Notice of Privacy practices.

WITH MY SIGNATURE I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS NUMBERED 1 THROUGH 6, AND THE GENERAL RELEASE OF INFORMATION.

______________________________________ ____________________

Client (Parent/Guardian) Signature Date