Patient Name: _____ Date: _____

CHILD/ADOLESCENT BIOPSYCHOSOCIAL HISTORY

PRESENTING PROBLEMS

Presenting problems: _____

_____

_____

Duration (months): _____

Additional Information: _____

_____

CURRENT SYMPTOM CHECKLIST (Rate intensity currently present)

None=This symptom not present at this time • **Mild**=Impacts quality of life, but not significant impairment of day-to-day functioning • **Moderate**= Significant impact on quality of life and/or day-to-day functioning • **Severe**=Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe	Unsure
Depressed mood	☐	☐	☐	☐	☐
Appetite disturbance	☐	☐	☐	☐	☐
Sleep disturbance	☐	☐	☐	☐	☐
Elimination disturbance	☐	☐	☐	☐	☐
Fatigue/low energy	☐	☐	☐	☐	☐
Psychomotor retardation	☐	☐	☐	☐	☐
Poor concentration	☐	☐	☐	☐	☐
Poor grooming	☐	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐	☐
Agitations	☐	☐	☐	☐	☐
Emotionality	☐	☐	☐	☐	☐
Irritability	☐	☐	☐	☐	☐
Generalized anxiety	☐	☐	☐	☐	☐
Panic attacks	☐	☐	☐	☐	☐
Phobias	☐	☐	☐	☐	☐
Obsessions/compulsions	☐	☐	☐	☐	☐

	None	Mild	Moderate	Severe	Unsure
Binging/purging	☐	☐	☐	☐	☐
Laxative/diuretic abuse	☐	☐	☐	☐	☐
Anorexia	☐	☐	☐	☐	☐
Paranoid ideation	☐	☐	☐	☐	☐
Circumstantial symptoms	☐	☐	☐	☐	☐
Loose associations	☐	☐	☐	☐	☐
Delusions	☐	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	☐
Aggressive behaviors	☐	☐	☐	☐	☐
Conduct problems	☐	☐	☐	☐	☐
Oppositional behavior	☐	☐	☐	☐	☐
Sexual dysfunction	☐	☐	☐	☐	☐
Grief	☐	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐	☐
Social isolation	☐	☐	☐	☐	☐
Worthlessness	☐	☐	☐	☐	☐

	None	Mild	Moderate	Severe	Unsure
Guilt	☐	☐	☐	☐	☐
Elevated mood	☐	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐	☐
Dissociative states	☐	☐	☐	☐	☐
Somatic complaints	☐	☐	☐	☐	☐
Self-mutilation	☐	☐	☐	☐	☐
Significant weight gain/loss	☐	☐	☐	☐	☐
Concomitant medical cond.	☐	☐	☐	☐	☐
Emotional trauma victim	☐	☐	☐	☐	☐

	None	Mild	Moderate	Severe	Unsure
Physical trauma victim	☐	☐	☐	☐	☐
Sexual trauma victim	☐	☐	☐	☐	☐
Emotional trauma perpetrator	☐	☐	☐	☐	☐
Physical trauma perpetrator	☐	☐	☐	☐	☐
Sexual trauma perpetrator	☐	☐	☐	☐	☐
Substance use/abuse	☐	☐	☐	☐	☐
Homicidal ideation	☐	☐	☐	☐	☐
Suicidal ideation	☐	☐	☐	☐	☐

Suicide Attempts: _____ number of times

Date of last attempt: _____

Other (specify): _____

_____

EMOTIONAL/PSYCHIATRIC HISTORY

Prior outpatient psychotherapy? _____ Yes _____ No
If yes on _____ occasions. Longest treatment by _____ for _____ sessions from _____/_____ to _____/_____
Prior provider name: _____
City: _____ State: _____
Phone: _____
Diagnosis: _____
Intervention/Modality: _____
_____
Beneficial? _____

Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?_____ Yes _____ No
If yes on _____ occasions. Longest treatment by _____ for _____ sessions from _____/_____ to _____/_____
Inpatient facility name: _____
City: _____ State: _____
Phone: _____
Diagnosis: _____
Intervention/Modality: _____
_____
Beneficial? _____
Has any family member had outpatient psychotherapy? _____ Yes _____ No
Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder
If yes, who/why (list all): _____
_____

EDUCATION LEVEL:

Current grade _____ School attending _____

FAMILY HISTORY

FAMILY OF ORIGIN
Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
Mother	☐	☐	☐
Father	☐	☐	☐
Stepmother	☐	☐	☐
Stepfather	☐	☐	☐
Brother(s)	☐	☐	☐
Sister(s)	☐	☐	☐
Other (specify)	☐	☐	☐

Father
Full name:_____
Occupation:_____
Education level:_____
General health:_____

Mother
Full name:_____
Occupation:_____
Education level:_____
General health:_____

Describe childhood family experience:
- ☐ Outstanding home environment
- ☐ Normal home environment
- ☐ Chaotic home environment
- ☐ Witnessed physical/verbal/sexual abuse toward others
- ☐ Experienced physical/verbal/sexual abuse from others

Age of emancipation from home:_____ Circumstances:_____
_____
Special circumstances in childhood:_____

List all persons currently living in patient's household:

Name	Age	Gender	Relationship to patient

List any siblings living outside the household:

Name	Age	Gender	Relationship to patient

Substance use history:

Family alcohol/drug abuse history:

☐ Mother ☐ Stepmother/live-in ☐ Grandparent(s) ☐ Spouse/significant other
☐ Father ☐ Stepfather ☐ Uncle(s)/Aunt(s) ☐ Siblings
☐ Other (Specify)_____

Patient alcohol and/or drug treatment history:

☐ Outpatient (age[s]_____) ☐ Inpatient (age[s]_____)
☐ 12-step program (age[s]_____) ☐ Stopped on own (age[s]_____)
☐ Other (age[s]_____) describe:_____

Substances used by patient: (complete all that apply)	First use age	Last use age	Current Use (yes/no)	Current frequency	Current amount
Alcohol					
Amphetamines/"speed"					
Barbiturates/"downers"					
Caffeine					
Cocaine					
Crack cocaine					
Hallucinogens (e.g. LSD)					
Inhalants (e.g. glue, gasoline)					
Marijuana or hashish					
Nicotine/cigarettes					
PCP					
Prescription					
Other					

Consequences of substance use (check all that apply):

☐ Hangovers ☐ Seizures ☐ Assaults ☐ Loss of control of amount used ☐ Withdrawal symptoms ☐ Medical complications
☐ Blackouts ☐ Overdose ☐ Arrests ☐ Sleep Disturbance ☐ Suicidal Impulse ☐ Relationship conflicts
☐ Binges ☐ Job loss ☐ Tolerance changes ☐ Other _____

DEVELOPMENTAL HISTORY (check all that apply for the child/adolescent patient)

Problems during mother's pregnancy:

☐ None ☐ Alcohol use ☐ Drug use ☐ Bleeding ☐ Kidney infection ☐ High blood pressure

☐ German Measles ☐ Emotional stress ☐ Cigarette use ☐ Other _____

Birth: ☐ Normal delivery ☐ Difficult delivery ☐ Cesarean delivery ☐ Complications

Birth weight: _____lbs _____ oz.

Infancy: ☐ Feeding problems ☐ Sleep problems ☐ Toilet training problems

Childhood health:

☐ Chicken Pox age: _____ ☐ German Measles age: _____ ☐ Red Measles age: _____ ☐ Mumps age: _____

☐ Rheumatic fever age: _____ ☐ Whooping cough age: _____ ☐ Scarlet Fever age: _____ ☐ Diptheria age: _____

☐ Lead poisoning age: _____ ☐ Poliomyelitis age: _____ ☐ Pneumonia age: _____ ☐ Tuberculosis age: _____

☐ Autism ☐ Mental retardation ☐ Ear infections ☐ Asthma

Significant injuries: _____ Chronic, serious health problems: _____

_____ _____

Delayed developmental milestones (check **only** those milestones that **did not** occur at expected age):

☐ Sitting ☐ Rolling over ☐ Standing ☐ Walking ☐ Feeding self

☐ Speaking words ☐ Speaking sentences ☐ Controlling Bladder ☐ Sleeping alone ☐ Dressing self

☐ Engaging peers ☐ Tolerating separation ☐ Playing cooperatively ☐ Riding tricycle ☐ Riding bicycle

Social interaction (check all that apply):

☐ Normal social interaction ☐ Isolates self ☐ Very shy ☐ Alienates self

☐ Dominates others ☐ Inappropriate sex play ☐ Associates with acting-out peers ☐ Other

Emotional/behavioral problems (check all that apply):

☐ Drug abuse ☐ Alcohol abuse ☐ Chronic lying ☐ Disobedient ☐ Repeats words of others

☐ Stealing ☐ Violent temper ☐ Fire-setting ☐ Indecisive ☐ Self-injurious threats

☐ Hyperactive ☐ Animal cruelty ☐ Assaults others ☐ Immature ☐ Self-injurious acts

☐ Distrustful ☐ Bizarre behavior ☐ Extreme worrier ☐ Impulsive ☐ Frequent daydreams

☐ Often sad ☐ Breaks things ☐ Easily distracted ☐ Not trustworthy ☐ Poor concentration

☐ Hostile/angry mood ☐ Lack of attachment ☐ Frequently tearful ☐ Other

Describe any other development problems or issues: _____

_____

Intellectual/academic functioning (check all that apply):

☐ Normal intelligence ☐ High intelligence ☐ Learning problems ☐ Authority conflicts

☐ Attention problems ☐ Underachieving ☐ Mild retardation ☐ Moderate retardation ☐ Severe retardation

Legal history:

☐ No legal problem ☐ Now on parole/probation ☐ Arrest(s) not substance-related

☐ Arrest(s) substance related ☐ Court ordered this treatment ☐ Describe last legal difficulty:

☐ Jail/prison ____ times ☐ Total time served:_____ _____

HEALTH SCREENING

Patient's Name: _____ Date: _____

Date of Birth: _____ Sex: _____F _____ M

Allergies: _____

1. Do you have or have you ever had any of the following?
   (please check yes or no)

	No	Yes	Please describe
Allergies			
Blood Disorder			
Bone or Joint Problems			
Cancer			
Diabetes			
Endocrine Disorders (e.g. thyroid)			
Epilepsy (seizures, convulsions)			
Gastrointestinal Disorders (stomach)			
Head injury			
Heart Disease			
HIV/AIDS Related Conditions			
Hypertension (high blood pressure)			
Hypoglycemia (low blood sugar)			
Liver Disease			
Lung Disease			
Physical Limitations			
Sexually Transmitted Disease (e.g. gonorrhea, syphilis)			
Other			

2. HOSPITALIZATIONS (list any operations, medical procedures, mental, drug, or alcohol abuse treatment)

Date	Procedure/treatment

3. MEDICATION currently taking (include prescription drugs; amount and frequency)

Name of Medication	Amount	Frequency	Date Started

4. MEDICAL PROCEDURES Physical exams; special test e.g. EKG, Blood Tests, X-rays, within past year

Exam/Test Performed	Date	Physician/Clinic

5. PRIMARY CARE DOCTOR

Name	Address	Phone	Date of Last Physical Exam

6. PREVIOUS MENTAL HEALTH TREATMENT

Date	Name of Provider	Address	Phone

Parent/Guardian/Patient's Signature: _____ Date: _____

Pediatric Symptom Checklist-17 (PSC-17)

Caregiver Completing this Form: _____ Date: _____

Name of Child: _____

		Please mark under the heading that best fits your child			For Office Use		
		NEVER	SOME-TIMES	OFTEN	I	A	E
1.	Fidgety, unable to sit still	☐	☐	☐			
2.	Feels sad, unhappy	☐	☐	☐			
3.	Daydreams too much	☐	☐	☐			
4.	Refuses to share	☐	☐	☐			
5.	Does not understand other people's feelings	☐	☐	☐			
6.	Feels hopeless	☐	☐	☐			
7.	Has trouble concentrating	☐	☐	☐			
8.	Fights with other children	☐	☐	☐			
9.	Is down on him or herself	☐	☐	☐			
10.	Blames others for his or her troubles	☐	☐	☐			
11.	Seems to be having less fun	☐	☐	☐			
12.	Does not listen to rules	☐	☐	☐			
13.	Acts as if driven by a motor	☐	☐	☐			
14.	Teases others	☐	☐	☐			
15.	Worries a lot	☐	☐	☐			
16.	Takes things that do not belong to him or her	☐	☐	☐			
17.	Distracted easily	☐	☐	☐			
	(scoring totals)	☐	☐	☐			

Scoring:

- Fill in unshaded box on right with: "Never" = 0, "Sometimes" = 1, "Often" = 2
- Sum the columns.
  PSC17 Internalizing score is sum of column I
  PSC17 Attention score is sum of column A
  PSC17 Externalizing score is sum of column E
  PSC-17 Total Score is sum of I, A, and E columns

Suggested Screen Cutoff:
PSC-17 - I ≥ 5
PSC-17 - A ≥ 7
PSC-17 - E ≥7
Total Score ≥ 15

Higher Scores can indicate an increased likelihood of a behavioral health disorder being present.

Created by W Gardner and K Kelleher (1999), and based on PSC by M Jellinek et al. (1988)
Formatted by R Hilt, inspired by Columbus Children's Research Institute formatting of PSC-17

QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (SELF-REPORT)

THIS SECTION FOR USE BY STUDY PERSONNEL ONLY.

Questionnaire completed on visit date ☐ **or** specify date completed: _____
DD-Mon-YYYY

Only the patient (subject) should enter information onto this questionnaire.

PLEASE CHECKMARK THE ONE RESPONSE TO EACH ITEM THAT IS MOST APPROPRIATE TO HOW YOU HAVE BEEN FEELING OVER THE PAST 7 DAYS.

1. Falling asleep:

☐0 I never took longer than 30 minutes to fall asleep.
☐1 I took at least 30 minutes to fall asleep, less than half the time (3 days or less out of the past 7 days).
☐2 I took at least 30 minutes to fall asleep, more than half the time (4 days or more out of the past 7 days).
☐3 I took more than 60 minutes to fall asleep, more than half the time (4 days or more out of the past 7 days).

2. Sleep during the night:

☐0 I didn't wake up at night.
☐1 I had a restless, light sleep, briefly waking up a few times each night.
☐2 I woke up at least once a night, but I got back to sleep easily.
☐3 I woke up more than once a night and stayed awake for 20 minutes or more, more than half the time (4 days or more out of the past 7 days).

3. Waking up too early:

☐0 Most of the time, I woke up no more than 30 minutes before my scheduled time.
☐1 More than half the time (4 days or more out of the past 7 days), I woke up more than 30 minutes before my scheduled time.
☐2 I almost always woke up at least one hour or so before my scheduled time, but I got back to sleep eventually.
☐3 I woke up at least one hour before my scheduled time, and couldn't get back to sleep.

4. Sleeping too much:

☐0 I slept no longer than 7-8 hours/night, without napping during the day.
☐1 I slept no longer than 10 hours in a 24-hour period including naps.
☐2 I slept no longer than 12 hours in a 24-hour period including naps.
☐3 I slept longer than 12 hours in a 24-hour period including naps.

5. Feeling sad:

☐0 I didn't feel sad.
☐1 I felt sad less than half the time (3 days or less out of the past 7 days).
☐2 I felt sad more than half the time (4 days or more out of the past 7 days).
☐3 I felt sad nearly all of the time.

QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (SELF-REPORT)

PLEASE CHECKMARK THE ONE RESPONSE TO EACH ITEM THAT IS MOST APPROPRIATE TO HOW YOU HAVE BEEN FEELING OVER THE PAST 7 DAYS.

Please complete either 6 or 7 (not both)

6. Decreased appetite:

- ☐0 There was no change in my usual appetite.
- ☐1 I ate somewhat less often or smaller amounts of food than usual.
- ☐2 I ate much less than usual and only by forcing myself to eat.
- ☐3 I rarely ate within a 24-hour period, and only by really forcing myself to eat or when others persuaded me to eat.

7. Increased appetite:

- ☐0 There was no change in my usual appetite.
- ☐1 I felt a need to eat more frequently than usual.
- ☐2 I regularly ate more often and/or greater amounts of food than usual.
- ☐3 I felt driven to overeat both at mealtime and between meals.

Please complete either 8 or 9 (not both)

8. Decreased weight (within the last 14 days):

- ☐0 My weight has not changed.
- ☐1 I feel as if I've had a slight weight loss.
- ☐2 I've lost 2 pounds (about 1 kilo) or more.
- ☐3 I've lost 5 pounds (about 2 kilos) or more.

9. Increased weight (within the last 14 days):

- ☐0 My weight has not changed.
- ☐1 I feel as if I've had a slight weight gain.
- ☐2 I've gained 2 pounds (about 1 kilo) or more.
- ☐3 I've gained 5 pounds (about 2 kilos) or more.

10. Concentration/decision-making:

- ☐0 There was no change in my usual ability to concentrate or make decisions.
- ☐1 I occasionally felt indecisive or found that my attention wandered.
- ☐2 Most of the time, I found it hard to focus or to make decisions.
- ☐3 I couldn't concentrate well enough to read or I couldn't make even minor decisions.

11. Perception of myself:

- ☐0 I saw myself as equally worthwhile and deserving as other people.
- ☐1 I put the blame on myself more than usual.
- ☐2 For the most part, I believed that I caused problems for others.
- ☐3 I thought almost constantly about major and minor defects in myself.

12. Thoughts of my own death or suicide:

- ☐0 I didn't think of suicide or death.
- ☐1 I felt that life was empty or wondered if it was worth living.
- ☐2 I thought of suicide or death several times for several minutes over the past 7 days.
- ☐3 I thought of suicide or death several times a day in some detail, or I made specific plans for suicide or actually tried to take my life.

EPI0905.QIDSSR

Patient Name: Date of Birth:

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

This instrument is designed for screening purposes only and not to be used as a diagnostic tool.
Permission for use granted by RMA Hirschfeld, MD

Zung Self-rating Anxiety Scale

Name: _____ Date: _____

Listed below are 20 statements. Please read each one carefully and decide how much the statement describes how you have been feeling **during the past week**. Circle the appropriate number for each statement.

	None or a little of the time	Some of the time	Good part of the time	Most or all of the time
1. I feel more nervous and anxious than usual.	☐	☐	☐	☐
2. I feel afraid for no reason at all.	☐	☐	☐	☐
3. I get upset easily or feel panicky.	☐	☐	☐	☐
4. I feel like I'm falling apart and going to pieces.	☐	☐	☐	☐
5. I feel that everything is all right and nothing bad will happen.	☐	☐	☐	☐
6. My arms and legs shake and tremble.	☐	☐	☐	☐
7. I am bothered by headaches, neck and back pains.	☐	☐	☐	☐
8. I feel weak and get tired easily.	☐	☐	☐	☐
9. I feel calm and can sit still easily.	☐	☐	☐	☐
10. I can feel my heart beating fast.	☐	☐	☐	☐
11. I am bothered by dizzy spells.	☐	☐	☐	☐
12. I have fainting spells or feel faint.	☐	☐	☐	☐
13. I can breathe in and out easily.	☐	☐	☐	☐
14. I get feelings of numbness and tingling in my fingers and toes.	☐	☐	☐	☐
15. I am bothered by stomachaches or indigestion.	☐	☐	☐	☐
16. I have to empty my bladder often.	☐	☐	☐	☐
17. My hands are usually dry and warm.	☐	☐	☐	☐
18. My face gets hot and blushes.	☐	☐	☐	☐
19. I fall asleep easily and get a good night's rest.	☐	☐	☐	☐
20. I have nightmares.	☐	☐	☐	☐

Score Total*: _____

*Score is for healthcare provider interpretation.

Adapted from Zung WWK. A rating instrument for anxiety. *Psychosomatics*. 1971;XII:371-379.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Patient Name: Date of Birth:

Married Parents/ Joint Custody

PARENT 1

Authorization to Provide Services to Minors
(Persons Under Age 18)

I,_____PARENT NAME_____, authorize mental health treatment services from _____PROVIDER NAME_____ for my son/ daughter, _____CHILD NAME_____, who is _____AGE_____ years of age. I agree to be present, and when requested, to participate in the treatment process.

I understand that all information given to _____PROVIDER NAME_____, and obtained from outside sources, will be retained in the patient's medical records and will remain confidential. No information will be shared with anyone outside of the practice of the provider listed above without consent of the parent or guardian.

_____

Parent/ Legal Guardian Printed Name

_____

Parent/ Legal Guardian Signature

NOTARY SIGN/STAMP

_____

Notary Stamp

_____

Date

_____

Date

1311 Union Street
Schenectady, NY 12308
518-374-6263

5 Hemphill Place
Malta, NY 12020
518-289-5072

All Providers are in Private Practice

Married Parents/ Joint Custody

PARENT 2

Authorization to Provide Services to Minors
(Persons Under Age 18)

I,_____*PARENT NAME*_____, authorize mental health treatment services from _____*PROVIDER NAME*_____ for my son/ daughter, _____*CHILD NAME*_____, who is _____*AGE*_____ years of age. I agree to be present, and when requested, to participate in the treatment process.

I understand that all information given to _____*PROVIDER NAME*_____, and obtained from outside sources, will be retained in the patient's medical records and will remain confidential. No information will be shared with anyone outside of the practice of the provider listed above without consent of the parent or guardian.

_____

Parent/ Legal Guardian Printed Name

_____

Parent/ Legal Guardian Signature

_____

NOTARY SIGN/STAMP

Notary Stamp

_____

Date

_____

Date

1311 Union Street
Schenectady, NY 12308
518-374-6263

5 Hemphill Place
Malta, NY 12020
518-289-5072

All Providers are in Private Practice

SINGLE PARENT/ SOLE CUSTODY

Authorization to Provide Services to Minors
(Persons Under Age 18)

I,_____*PARENT NAME*_____, authorize mental health treatment services for _____*CHILD NAME*_____, my son/ daughter, who is _____*AGE*_____ years of age. I agree to be present, and when requested, to participate in the treatment process. By signing below I attest that I possess sole decision making rights for all medical care for my child. I hereby hold harmless Union Street Counseling Services LLC., and provider_____*PROVIDER NAME*_____ from any claims made by another parent/legal guardian regarding the above mentioned decision making rights.

I understand that all information given to _____*PROVIDER NAME*_____, and obtained from outside sources, will be retained in the patient's medical records and will remain confidential. No information will be shared with anyone outside of the practice of the provider listed above without consent of the parent or guardian.

_____

Parent/ Legal Guardian Printed Name

NOTARY SIGN/STAMP

_____

Parent/ Legal Guardian Signature

_____

Notary Stamp

_____

Date

_____

Date

1311 Union Street
Schenectady, NY 12308
518-374-6263

5 Hemphill Place
Malta, NY 12020
518-289-5072

All Providers are in Private Practice

PRMARY CARE PROVIDER (PCP) COORDINATION OF CARE

This release is for the purpose of coordination of care between your provider at Union Counseling and your Primary Care Provider/ General Practitioner. **COMPLETE TOP SECTION ONLY.**

Patient Name:_____

Patient Date of Birth:_____

Patient Address:_____

_____

Primary Care Provider (PCP) Name:_____

Address:_____

_____

Phone:_____ Fax:_____

Optional Refusal (Initial):

_____I **AM NOT** currently receiving services from a PCP or other medical practitioner

_____I **DO NOT** want information shared with my PCP

NOTICE: *By signing, I hereby authorize the behavioral health clinician/facility listed below to release information to the practitioner/provider listed above. The reason for disclosure is to facilitate continuity and coordination of treatment.* ***This consent will last one year from the date signed****. I understand that I may revoke my consent in writing at any time. I understand that my treatment is not conditional in any way on my consenting to this disclosure.*

Signature of Patient/Patient's Representative:_____**Date**:_____

Print Name of Patient/Patient's Representative:_____

Relationship of Representative (parent, guardian, etc.)_____

(Please provide necessary documentation proving authority if requested)

THIS DOCUMENT IS FOR COORDINATION OF CARE ONLY FOR OUR MUTUAL PATIENT LISTED ABOVE

Should you have any further questions, please contact the office selected below.

Diagnosis: _____

_____

_____

Medications:_____

_____

_____

I recommend the following course of treatment for this patient:

THERAPY: _____Individual ____Family _____Group _____Couple

MEDICAL: _____Medication Management _____Substance Abuse Treatment

Provider Name:_____Credential:_____

Provider Signature:_____Date:_____

☐ 1311 Union Street Schenectady, NY 12308 Phone:(518)374-6263 Fax: (518)374-1778

☐ 5 Hemphill Place Malta, NY, 12020 Phone:(518)289-5072 Fax: (518)289-5225

DATE SENT_____ STAFF INITIAL_____

CONTROLLED SUBSTANCE AGREEMENT

This Agreement Outlines Your Provider's Guidelines for Proper Use of Controlled Medications

Controlled medications (defined as controlled schedule medications by the US Department of Justice Drug Enforcement Administration) are very useful but are sometimes abused and are closely controlled by all levels of government. They are intended to improve function, and they are only a part of a comprehensive treatment plan created between you and your provider.

The long-term use of benzodiazepines is controversial because it is not certain that they are beneficial in the long term. Patients who are prescribed this class of medications are at risk for developing an addictive disorder or suffering a relapse from a prior addiction. Where indicated, these medications will be prescribed on a short-term basis only.

Controlled medication(s) must be prescribed **ONLY** by my Provider, whose signature is below.

PROVIDER SIGNATURE:_____

DATE: _____

During his/her absence, controlled medication(s) must **ONLY** by prescribed by my Provider's designated covering provider.

Controlled medication(s) prescribed to me by my provider must be obtained at the pharmacy below:

PHARMACY:_____ PHONE_____

ADDRESS:_____

_____

If I change my pharmacy, I must inform my Provider in advance of dispensing a prescription(s).

1311 Union Street
Schenectady, NY 12308
518-374-6263

5 Hemphill Place, Suite 121
Malta, NY 12020
518-289-5072

All Providers are in Private Practice

Patient Name: Date of Birth:

PLEASE INITIAL EACH LINE BELOW TO ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTOOD ALL POLICIES:

_____ I understand that my prescribing provider may require me to be seen at specified intervals in order to continue to be prescribed controlled medications.

_____ I give my provider permission to discuss my medical condition with pharmacists and other professionals who provide my health care.

_____ I will **NOT** share, sell, or otherwise permit **ANYONE ELSE** to take my medications.

_____ I understand that urine tests, blood tests, or pill counts may be required.

_____ I will **NOT** drink large amounts of alcohol while taking my medication.

_____ I will **NOT** purchase or otherwise obtain any illegal drugs.

_____ I understand that medications will **NOT** be replaced if they are lost, stolen, or destroyed.

_____ If legal authorities raise questions about my treatment, I waive my confidentiality, and understand that these authorities may be given ALL of my records of controlled medication use.

_____ Information in my chart, including this agreement, will be available to any facility or provider involved in my care.

_____ If I do not follow my full treatment plan, the medication may be discontinued by my provider.

REFILLS OF CONTROLLED SUBSTANCE MEDICATIONS:

_____ I understand that early refills will not be given and that I must keep appointments with my provider to obtain renewals.

_____ Will be given on **WEEKDAYS** during business hours. I must allow **5 WORKING DAYS** for refills to be approved and written by my provider.

_____ Will **NOT** be made as an "Emergency".

_____ If I do not follow these rules, my Provider may stop all refills and I may be discharged from the Provider's care.

I affirm that I have full right and power to sign, be bound by this agreement, and that I have read, understand, and accept all of its terms.

PATIENT NAME: _____

RESPONSIBLE PARTY SIGNATURE: _____

RESPONSIBLE PARTY NAME(IF DIFFERENT FROM PATIENT): _____

DATE: _____