IF PATIENT IS A MINOR (AGE 18 & UNDER)	
PRIMARY CONTACT	
Last Name	First Name, M.I.
Home Address	City, State ZIP
Phone	
Relationship to Patient	
MARITAL STATUS OF PARENTS:	(If divorced or separated, please bring copy of legal documents on custody arrangement to the first visit)
MOTHER	
Last Name	First Name, M.I.
Home Address	City, State ZIP
Phone	
FATHER	
Last Name	First Name, M.I.
Home Address	City, State ZIP
Phone	
CHILD'S LEGAL GUARDIAN	
Last Name	First Name, M.I.
Home Address	City, State ZIP
Phone	
FOSTER PARENT	
Last Name	First Name, M.I.
Home Address	City, State ZIP
Phone	
SOCIAL WORKER	
Last Name	First Name, M.I.
Address	City, State ZIP
Work Phone/Ext.	

Child & Adolescent Background Information and Psychosocial Intake Summary

P.E.R.M.A. Mental Health

CONFIDENTIALITY STATEMENT

(MUST BE READ & SIGNED PRIOR TO APPOINTMENT)

Information gathered in the course of Perma Mental Health's (PMH) work with me will remain confidential. However, there are exceptions to this confidentiality as mandated by law.

1. **If information is shared with PMH that leads the staff to believe that I/my minor child will cause injury to another person, PMH is obligated to either contact that person and/or the police in order to warn of a potential threat.**

2. **In cases where child abuse (where a child is in threat of harm, imminent danger, or has been harmed) is related to the staff, PMH is mandated to contact Child Protective Services (CPS).**

3. **If it were felt that I/my minor child am/is actively suicidal, PMH will attempt to take reasonable precautions to protect me/my minor child from harm.**

4. **Additionally, I understand that PMH does comply with all court ordered subpoenas for medical records.**

In all cases where there is a need to report, the situation will be discussed with me in order to help me understand the need to report and in the hope of securing my consent.

I UNDERSTAND THE EXCEPTIONS TO CONFIDENTIALITY AS DESCRIBED ABOVE.

_____

Patient's Name

_____ _____ _____

Parent/Guardian's Name | Parent/Guardian's Signature (REQUIRED) | Date

CONSENT TO PSYCHOTROPIC MEDICATIONS

(MUST BE READ & SIGNED PRIOR TO APPOINTMENT)

Child's Name:_____ Date of birth:_____ Date: _____

Type(s) of medications that may be prescribed when being seen by the psychiatrist include psychoactive medications including but not limited to antidepressants, antipsychotics, anxiolytics, stimulants and various others to treat certain psychiatric conditions.

Your doctor will always discuss the risks and benefits of the medications prescribed and also provide written information or other resources as desired and as available in addition to the information provided at the pharmacy. It is your right and we request your diligence in requesting and receiving information about any of the prescribed medications. If you do not feel your concerns have been addressed, it is your responsibility to make your concerns and questions known to the clinic in a timely manner. We will work hard to answer your questions and provide any informational resources as soon as possible.

I agree that I will discuss with my provider the name, type, class risks and benefits of any medication prescribed and if I have any concerns or further questions I will make them known. I hereby give my consent to receive prescriptions for medications from my provider (or for my child/dependent as applicable).

Parent/guardian signature:_____ Date: _____

Authorization for Use and Disclosure of Protected Health Information

(MUST BE READ & SIGNED PRIOR TO APPOINTMENT)

I authorize Perma Mental Health, PLLC *to release/obtain the protected health information of*

*Patient Name: _____ Birth date: _____

Address: _____ Phone #: _____

To/From* Institution: Including Name_____

Address: _____ City, State, Zip: _____

To/From* Institution: Including Name_____

Address: _____ City, State, Zip: _____

*Information to be disclosed:	*Purposes for Use and/or Disclosure:
Date(s) of Service: _____ □ Discharge Summary □ ER report □ History & Physical □ Lab Results □ Consults □ X-Ray/Imaging Reports □ Operative Reports □ Entire Record	□ At the request of the individual □ Legal Purposes

I agree to the release of the following information even if it should contain in my medical record: Acquired Immune Deficiency Syndrome (AIDS) or HIV, Alcohol and/or drug abuse treatment, or behavioral or mental health services.

*Unless otherwise revoked, this authorization will expire on the following date or event: _____If a date or event is not specified, this authorization will expire one year from my date of signature below.

This authorization is voluntary. I understand that I can refuse to sign this authorization and Perma Mental Health, PLLC will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this authorization except as allowed under federal privacy laws for: (i) research-related treatment; or (ii) health care provided solely for disclosure to a third party or (iii) health plan initial enrollment/eligibility determinations, underwriting or risk rating determinations.

I understand that I may revoke this authorization at any time by notifying Perma Mental Health Clinic, in writing, of my revocation. I understand that the revocation will not apply to any information that already was released in reliance on this authorization.

I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy regulations.

I hereby release Perma Mental Health, PLLC from all liability and all claims of any nature whatsoever pertaining to the disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to or by Perma Mental Health, PLLC

*Signature: _____ *_____

Parent or Guardian Print Name and DATE

(MUST BE READ & SIGNED PRIOR TO APPOINTMENT)

1. ***Consent for Treatment***

   I or my minor child/ward wish to receive mental health/psychiatric/ psychology and treatment at Perma Mental Health, PLLC (PMH). Accordingly, I give consent for any and all mental health services rendered to me or my minor child/ward under the general and specific instructions of the attending psychiatrist/psychologist as may be determined to be appropriate by their professional judgment.

   I am aware that the practice of medicine/psychiatry, psychology is not an exact science. I acknowledge that this facility has not made any guarantees to me or my minor child/ward as to the results of treatments or examinations. I am also aware that I should ask the therapist/nutritionist any questions that I may have about my or my minor child's/ward's diagnosis, treatment, risks or complications, alternative forms of treatment, and/or anticipated results of treatment.

2. ***Disclosure of Information for Payment Purposes***

   I understand my or my minor child's/ward's health medical information will be sent to my insurance carrier for billing purposes for any treatment or counseling I may or my minor child/ward may receive at this medical facility. As such, I understand that this health information may contain entries or information relating to sexually transmitted diseases, including Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS), mental health diagnoses, psychiatric impairment and/or drug, alcohol or other substance abuse and other personal information. I understand that according to Idaho law, I may choose to pay for services pertaining to HIV or AIDS treatment if I do not want my or my child's/ward's health information to be provided to my insurance company. I agree to notify PMH of my wishes regarding payment before these services are provided. I also understand that if I fail to pay for the services, the information will be sent to my insurance company.

3. ***Email Policy***

   I understand that the email policy is if the patient may choose to email us anything they want, but we don't recommend it because email is not 100% secure; PERMA can never send any information through email such as diagnosis or medication info. Our scheduling system will automatically email you a reminder and we may email you to get you on the schedule. By signing below you consent to email communication and can opt out at anytime.

4. ***Non-Discrimination Policy***

   This medical facility will admit and treat patients within its capabilities regardless of race, color, national origin, religious beliefs, sex, sexual orientation, marital status, veteran's status, age, political beliefs, or disability.

5. ***Financial Agreement***

   I understand that I will receive a bill from this medical facility for these services. I understand and agree to pay all charges for services rendered and that I am obligated to pay for services in accordance with the regular rates and terms of this medical facility. This medical facility reserves the right to charge a Late Payment Fee and/or a Returned Check fee.

   If I choose to pay all charges myself, I will notify this medical facility prior to receiving service.

   Should the account be referred to an attorney or collection agency for collections, I agree to pay any reasonable attorney's fees, collection expenses and interest at the statutory rate on all delinquent accounts, whether or not the account is referred to a collection agency.

   Missed Appointments: I also agree to pay the full cost for all visits missed or canceled late unless I notify PMH of the cancellation at least 24 hours in advance of the scheduled appointment. I recognize that missed appointments and late cancellations will be charged directly to me unless prohibited by my insurance plan. These fees will not be billed to my insurance.

   Prescription Refills: I understand that controlled substance prescriptions expire 72 hours after being written by the doctor. If I fail to get the prescription filled within the 72 hours I will be charged fee for my doctor to rewrite the prescription. This fee will not be billed to my insurance.

6. ***Medicare Coverage (if applicable)***

   I certify that the information I have given in applying for payment under Medicare is correct. 1 authorize the Social Security Administration to release information about my Medicare effective dates and Medicare claim number to this medical facility. I authorize any holder of medical or related information about me to release any information needed to process this or a related Medicare claim to the Social Security Administration or its intermediaries. I request that payment of benefits be made on my behalf to this medical facility for any services provided to me by this medical facility.

7. ***Assignment of Benefits***

I hereby authorize assignment of my medical insurance benefits I am due to this medical facility for application to my bill for medical services I received. I further authorize this medical facility to receive direct payment from all such benefit payments. I agree to remain responsible and liable for payments of all amounts due this medical facility and not received from my insurance carrier(s). I understand this medical facility is submitting claims on my behalf as a courtesy. I WILL NOT REVOKE THIS ASSIGNMENT FOR ANY REASON.

8. ***Patient's Rights and Responsibilities***

My signature below confirms that I agree to these terms and conditions and that I have received the information on my Rights and Responsibilities as a patient.

9. ***Information to other providers***

I understand that in the course of my treatment and/or making arrangements for my care, my information may be shared with other providers. If I prefer that PMH not use or share my information for this purpose, I may submit a written request for consideration per this facility's Notice of Privacy Practices.

ACKNOWLEDGEMENT OF RECEIPT OF THIS MEDICAL FACILITY'S NOTICE OF PRIVACY PRACTICES

____ I HAVE RECEIVED A COPY OF THIS FACILITY'S NOTICE OF PRIVACY PRACTICES

_____ THE PATIENT OR THEIR DULY AUTHORIZED REPRESENTATIVE IS UNABLE TO MAKE THIS ACKNOWLEDGEMENT.

MINORS OR INCAPACITATED PERSONS - THE PATIENT IS:

A MINOR _____ YEARS OF AGE

INCAPACITATED AND UNABLE TO SIGN FOR THE FOLLOWING REASON(S):

_____

I HAVE READ THIS CONSENT AND I AM THE PATIENT, OR THE PATIENT'S DULY AUTHORIZED REPRESENTATIVE. ON MY OWN BEHALF (OR ON BEHALF OF THE PATIENT), I ACCEPT AND AGREE TO BE BOUND BY ALL OF THESE TERMS AND CONDITIONS OF SERVICE.

_____ _____ _____

PARENT OR REPRESENTATIVE'S SIGNATURE DATE TIME

_____

PRINT NAME

_____

RELATIONSHIP TO PATIENT

REPRESENTATIVE: PLEASE DESCRIBE YOUR AUTHORITY TO ACT ON BEHALF OF THE PATIENT:_____

WITNESS SIGNATURE: _____ _____ _____ _____

DATE TIME PLACE

Child & Adolescent Background Information and Psychosocial Intake Summary

P.E.R.M.A. Mental Health

Today's Date: _____

Name: _____ Age: _____ Birthdate: _____ Gender: _____

Ethnicity: _____ Religion: _____

School/Grade:_____ Special school accommodation? Sp.Ed./Alt. Ed./Reg.ED. _____

Person completing the questionnaire:_____

If you need any more space for any of the following questions please use the back of the sheet.
Primary reason(s) for seeking services:

❒Alcohol/drugs ❒Anger management ❒Anxiety ❒ Behavior problems

❒Coping with medical illness ❒Depression ❒Eating disorder

❒Family concerns ❒Fears/phobias ❒Sexual concerns

❒Sleeping problems ❒Suicidal feelings ❒Marital/relationship problems

❒Psychological/psychiatric evaluation ❒Recent loss/death ❒Other concerns (specify):

_____

HISTORY OF PRESENTING PROBLEM:

What do you feel is your child or adolescent's problem(s) is?

_____

When and how did the problem(s) start?

_____

What do you believe causes the problem(s)?

_____

How severe have the problem(s) become? Is the problem(s) affecting your family, school and/or work? If so, please explain. _____

What has already been done to address the problem(s) and what were the results?

_____

_____

Please circle or check problems your child/adolescent experienced in the past:

Feelings of depression	Feelings of anxiety	Family problems
Behavioral problems	School / academic	Bizarre behaviors
Peer relationships	Isolation & withdrawal	Sleep disturbances
Substance abuse	Impulse control	Legal problems
Developmental delays	Physical/emotional/sexual abuse	Obsessions or compulsions

Other (Please explain):

_____

Are you currently involved in any legal proceedings (e.g., a civil suit, divorce, custody case, bankruptcy, etc)? ❒Yes ❒No

If yes, please explain:_____

If any of the following information does not apply or has been filled out in other sections, please feel free to omit, however, you are responsible for providing a complete and accurate history.

DEVELOPMENTAL HISTORY:

Pregnancy. Circle or check all that apply.

Mother with prior difficulties w/pregnancies	Miscarriage(s)
Unplanned pregnancy	Gap in prenatal care
Mother w/fevers, illnesses, or infections	Premature
Mother exposed to medications or x-rays	Over due
Mother used alcohol, tobacco or drugs	Mother bleeding
Mother w/diabetes, toxemia or high blood pressure	

Explain: _____

Labor and Delivery. Circle or check all that apply.

Unusual or difficult labor	Baby needing special care	Mother w/post-partum blues
Concerns of baby at birth	Baby in hospital longer than mother	Mother with infections

Explain: _____

Infancy and Early Childhood. Circle or check all that apply.

Infant not breast fed	Infant difficult to care for	Attachment problems
Infant cried a lot	Feeding problems	

Explain: _____

Compared with others in the family, child's development was:

❒ slow ❒average ❒ fast

PAST & CURRENT MEDICAL DATA:

Are you currently in counseling or receiving mental health or substance abuse services from any other provider? ❒Yes ❒No

If yes, with whom, and when? _____

Have you ever received counseling, mental health or substance abuse services, and/or psychiatric hospitalizations? ❒Yes ❒No

Is there a current Pediatrician or Family Practice Provider? If so, please list below:

Provider or Institution Name	*Approximate Dates*	*Reason*	*Type of Treatment*	*Results*

Has your child / adolescent ever tried to harm themselves or others? If so, when?

_____

Is your child or adolescent on PSYCHIATRIC medications **at this time**?* ❒Yes ❒No If so, please list below:

Name of Medication	*Approximate Dates*	*Dosage (in mg)*	*Side Effects*	*Positive Effects*

Was your child or adolescent on PSYCHIATRIC medications **in the past**?* ❒Yes ❒No If so, please list below:

Name of Medication	*Approximate Dates*	*Dosage (in mg)*	*Side Effects*	*Positive Effects*

Have you ever had psychological testing? ❒Yes ❒No

If so, approximately when and where? _____

Any environmental allergies? _____

Any <u>allergies</u> or adverse reactions to medications? ❒Yes ❒No

If so, please explain: _____

Any ongoing physical complaints made by your child/adolescent? ❒Yes ❒No

If so, please elaborate: _____

Current height: _____ Current weight: _____

Has your child/adolescent experienced any of the following? Circle or check those that apply.

Head injury	Recurrent vomiting	Stomach aches
Loss of consciousness	Diarrhea with dehydration	Hernia
Convulsions or seizures	Poison ingestion	Fainting spells
Odd movements or sounds	Undescended testicles	Double vision
Difficulty breathing	Urinary tract infections	Sleep disorders
Meningitis or encephalitis	Asthma or bronchitis	Tremors
Chronic ear infections	Nervous twitches or tics	Heart disorder

Other: _____

For FEMALES only:

Has menses begun?

If so, when? _____

Are they regular?

Any past or current pregnancies?

<u>FAMILY MENTAL HEALTH HISTORY</u>

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

❒ Anxiety ❒ Depression ❒ Learning problems/disabilities ❒ Dyslexia

❒ ADHD ❒ Suicide ❒ Behavior problems ❒ Autism

❒ Bipolar/Manic-Depression ❒ Schizophrenia ❒ Substance Abuse

FAMILY MEDICAL HISTORY

Has anyone in the child's/adolescent's family had medical problems? Circle or check those that apply.

❒ Birth defects ❒Seizures/neurological problems ❒Thyroid/endocrine problems ❒Tourettes/tic disorder ❒Inherited diseases ❒Others: _____

FAMILY ENVIRONMENT AND SUPPORT SYSTEM

Who is living in the Home?

Name	*Relationship*	*Age*	*Grade, Education or Employment*

Is there anything notable, unusual, or stressful about the child's relationship with the mother or the father? ❒Yes ❒No

If Yes, please explain: _____

Significant Others (e.g.) boyfriend, girlfriend, caretakers, siblings)

Name	*Relationship*	*Lives w/who*	*Contact Frequency*

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in therapy? ❒Yes ❒ No

If Yes, please describe: _____

Mother's other marriages and/or significant relationships.

Married to/living with/dating:_____from (date)_____to_____

Married to/living with/dating:_____from (date)_____to_____

Father's marriages and/or significant relationships.

Married to/living with/dating:_____from (date)_____to_____

Married to/living with/dating:_____from (date)_____to_____

Circle or check all that apply.

Significant change in grades	Repeated grade(s)	Special education
Truant	Tardiness	Receives extra help
Suspensions/detentions	Special classes	Dislikes school
Doesn't complete work	School testing	

Explain: _____

SOCIAL DEVELOPMENT:

Where was the child born and raised? _____ Languages spoken at home? _____

Is your child involved in outside activities?

Activity	*Program/Contact Person*	*Age & Frequency*

Please rate your child's/adolescent's temperament on this scale by circling the number on this five point scale.

Mellow	1	2	3	4	5	Intense
Cautious	1	2	3	4	5	Adventurous
Happy	1	2	3	4	5	Sad
Social/outgoing	1	2	3	4	5	Isolate/shy
Adapts easily	1	2	3	4	5	Never warms up
Calm	1	2	3	4	5	Hyperactive
Feminine	1	2	3	4	5	Masculine
Dependent	1	2	3	4	5	Independent
High self esteem	1	2	3	4	5	Low self esteem

Circle or check all that apply:

Difficulty making friends	Difficulty keeping friends	Breaking rule or laws
Promiscuity	Fights with others	Picked on by others
Bullies others	"Wrong kinds of friends"	Attracted to the same sex
Attracted to the opposite sex		

Please explain:_____

<u>OTHER INFORMATION</u>:

Has your child/adolescent ever been placed outside the family home? If yes, please explain.

_____

What are your child's/adolescent's interests and hobbies?

_____

_____	_____	_____
Print Name	Parent/Guardian Signature	Date

FOR ANY EMERGENCIES, PLEASE CALL 911 OR GO TO YOUR NEAREST EMERGENCY ROOM

Useful numbers:

National Suicide Prevention Lifeline
Need to talk to someone right away?
Need help? In the U.S., call 1-800-273-8255

IDAHO - STATEWIDE
Suicide Prevention & Hotline
24 hours / 7 days, call 1-800-564-2120

IDAHO Careline:
Information and Referral:
M-F, 8-6pm MST
211 or **1-800-926-2588**

Serving Ada, Boise, Valley & Elmore Counties
Regional Mental Health Services-Boise
24-Hour Crisis Line
(208) 334-0808
1-800-600-6474

Idaho Department of Health & Welfare
www.healthandwelfare.idaho.gov/