Pinnacle Health Services

INTAKE/BIOPSYCHOSOCIAL HISTORY FORM - ADOLESCENT

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) _____ May we leave a message? ☐ Yes ☐ No

Cell/Other Phone: ( ) _____ May we leave a message? ☐ Yes ☐ No

E-mail: _____ May we email you? ☐ Yes ☐ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

With whom do you live? _____

Brought in for counseling by: _____ Relationship to you: _____

What school do you go to? _____ Grade: _____

Are you here because you want counseling or because someone else wants you to get counseling? ☐ I do ☐ Someone else does: _____

Referred by (if any): ☐ Doctor ☐ Family ☐ Friend ☐ Other _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Describe your current physical health: ☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Very Poor

Please list any health concerns: _____

Are you currently under a doctor's care?_____ (If yes, please describe)_____

_____

Physician's Name:_____ Address:_____

_____

Please list any prescription and/or over-the-counter medication you are currently taking:

_____

How would you rate your current sleeping habits?
☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please specify any sleep problems you are currently experiencing:
☐ Sleeping too little ☐ Sleeping too much ☐ Poor quality sleep ☐ Disturbing dreams
☐ Other_____

Are you having any difficulty with appetite or eating habits? ☐ Yes ☐ No
If yes, check where applicable: ☐ Eating less ☐ Eating more ☐ Binging ☐ Restricting ☐ Purging

Are you currently experiencing overwhelming sadness, grief, or depression? ☐ No ☐ Yes
If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias? ☐ No ☐ Yes
If yes, when did you begin experiencing this? _____

Have you previously received any type of mental health services (counseling, psychotherapy, psychiatric services)?
☐ No ☐ Yes, previous therapist/practitioner: _____

Please describe the experience and issues you covered in therapy: _____

_____

Have you ever been prescribed psychiatric medication (For depression, anxiety, ADHD, etc.)?
☐ No ☐ Yes - Please list and provide dates: _____

_____

Have there been any traumatic events in your life? ☐ No ☐ Yes
If yes, please describe: _____

Have you ever been sexually abused? ☐ No ☐ Yes

Have you ever been physically abused? ☐ No ☐ Yes

Have any of the other children in your home been abused? ☐ No ☐ Yes

Have you ever witnessed violence between adults? ☐ No ☐ Yes

How would you describe your interactions with kids your own age?

_____

_____

How would you describe your interactions with adults?

_____

_____

Have you gone through periods of major stress? ☐ No ☐ Yes

Are you using alcohol or other drugs? ☐ No ☐ Yes
If yes, please list: _____

Are you sexually active? ☐ No ☐ Yes

Have you had any legal problems (shoplifting, tagging, etc.)? ☐ No ☐ Yes _____

ACADEMIC AND SOCIAL

How well do you do in school? _____

_____

Do you like school? ☐ No ☐ Yes

Do you receive any special services (IEP, 504 Plan): _____

_____

Are you satisfied with your current social life? Please explain: _____

_____

Are you involved with any social groups, churches, activities, hobbies, sports teams, etc.?

_____

_____

FAMILY HISTORY

Your biological parents' names and ages: _____

_____

Adults with whom you live: _____

_____

List names and ages of biological brothers and sisters: _____

_____

List names and ages of stepbrothers and sisters and other children living in the home:

_____

_____

Were you adopted? Yes _____ No _____ If yes, at what age: _____

Have you ever lived in foster care or a similar living arrangement? Yes _____ No _____
If yes, at what age(s): _____

How well are you doing with your home life? _____

_____

Has there been a death of a family member? Yes _____ No _____
If yes, what relationship was this person to you? _____

In the section below, identify if there is a **family history** of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

		List Family Member
Alcohol/Substance Abuse	☐ yes ☐ no	_____
Anxiety	☐ yes ☐ no	_____
Depression	☐ yes ☐no	_____
Domestic Violence	☐ yes ☐no	_____
Eating Disorders	☐ yes ☐no	_____
Obesity	☐ yes ☐no	_____
Obsessive Compulsive Behavior	☐ yes ☐no	_____
Schizophrenia	☐ yes ☐no	_____
Suicide Attempts	☐ yes ☐no	_____
Suicide Completions	☐ yes ☐no	_____

PRESENTING PROBLEM(S)

In your own words, briefly describe the main problem which prompted you to seeking counseling at this time:_____

_____

_____

Please check any of the following that are currently troubling you. Put **two** checks by those items which are most important. You may add any comments you would like:
****Please note** that **intent** to harm yourself or another person cannot be protected as confidential information (cannot, by law, be kept secret by the counselor).

___Abortion/Adoption
___Adjustment Problems
___Anger/Temper
___Anxiety (worry)
___Child Abuse
___Concentration
___Death of a loved one
___Depression
___Failure
___Family Conflict
___Fear
___Friends
___Frustration
___Guilt
___Loneliness
___Loss of Interest
___Loss of Pleasure
___Memory Problems
___Panic
___Rape
___Rebellion
___Rejection
___Religious/Spiritual Issues
___Repetitive Ideas
___School Problems
___Sexual Abuse
___Self-Esteem
___Shy/Awkward
___Sleep Problems
___Suicide Attempt(s)
___Suicidal Thoughts
___Wish to Hurt Someone
___Withdrawal

Do you have thoughts of killing yourself or others? ☐ No ☐ Yes _____

Do you harm yourself (cutting, burning, hair pulling, pinching)? ☐ No ☐ Yes If yes, how do you harm yourself and how often: _____

_____

What are your strengths? _____

_____

What would you like to accomplish out of your time in therapy? _____

_____

_____

_____

Pinnacle
Health Services

CONSENT TO TREATMENT OF MINOR

Name of minor: _____ Date of birth: _____

Age: _____ years

I, _____, am the legal custodian of the above-named minor.

Please check one.

- ☐ I have full legal authority to consent to treatment of the minor without obtaining consent or approval of another person.
- ☐ I have joint custody of the minor pursuant to a decree that allows me to consent to treatment of the minor without the consent of another person.
- ☐ I have joint custody of the minor pursuant to a decree that requires both my consent and the consent of another person.
- ☐ I am a minor client who is emancipated or married, parental/guardian consent is not required.
- ☐ I am a minor client who is not married or emancipated but has lived apart from my parents/guardian and has been self-sustaining for at least the past 90 days and understand that parental/guardian notification may be required.

In signing this document, I also understand Pinnacle Health Services does not act as a custody evaluator or a divorce mediator. I also acknowledge Pinnacle Health Services will not participate in court related matters unless subpoenaed by a judge. If subpoenaed by a judge, I understand this is not included in my counseling service and a separate charge of $1800.00 per day will be required at time of service.

I authorize Pinnacle Health Services to provide counseling to the minor in connection with mental health and/or other personal problems.

_____
Parent or Legal Guardian Print Name

_____ Date: _____
Parent or Legal Guardian Signature

Pinnacle Health Services

Pinnacle Health Services
547 E Pine Street, Suite 201
Phone (541) 423-8151 Fax (541) 423-8508

Therapy Agreement & Informed Consent

Leslie Rheault, LPC, Shannon Modjeski, LPC, Bronson Dull, LCSW,
Kacy Mullen, PhD

Before starting mental health therapy, it is important to know what to expect, and to understand your rights as well as commitments. This consent form is an attempt to be as transparent with you as I can about the therapy process, so you are fully informed prior to starting treatment. I will give you a copy to take home.

Treatment Philosophy

- Mental health therapy is a process of opening up about your life experiences and your genuine thoughts and feelings in order to increase your self-awareness of psychological and emotional conflicts that keep you stuck in unwanted patterns. This means we will focus on helping you uncover the root causes, thought patterns, emotions, and actions that contribute to current life distress. For the therapy to be most successful, you will have to work on things we discuss both during our sessions and at home. I may also make other appropriate referrals if I find it necessary (I.e., psychiatric evaluation; neuropsychological evaluation). Remember, you always retain the right to request change in treatment or to refuse treatment at any time.

- The therapy may involve temporary periods of discomfort as you begin to work through past trauma or confront psychological conflicts you have previously been avoiding. You may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, therapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

- Your psychotherapy sessions will be approximately 50-60 minutes in length and are generally conducted once per week. We will discuss if a different meeting frequency (i.e., once every two weeks) will work best depending on your specific situation.

- Treatments supported by research to help people with specific problems are generally shorter-term in nature (e.g., 16-20 sessions). By learning helpful skills and ways of thinking about your concerns in treatment, clients often find they are well equipped to manage on their own or with occasional support.

- **APPOINTMENT RESCHEDULING OR CANCELING**: Once an appointment is set, that time is reserved for you. I cannot typically fill that time within 24 hours. Therefore, APPOINTMENTS MUST BE RESCHEDULED OR CANCELED **48 HOURS IN ADVANCE**; I may make an exception for a true emergency.

- I can be reached at the clinic by calling (541) 423-8151. I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on the clinic's confidential voicemail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe: 1) contact Jackson County Mental Health Crisis Line (541-774-

Pinnacle Health Services

Pinnacle Health Services
547 E Pine Street, Suite 201
Phone (541) 423-8151 Fax (541) 423-8508

Therapy Agreement & Informed Consent Continued:

8201); 2) go to your Local Hospital Emergency Room; 3) Contact the Mental Health National Helpline at 1-800-662-4357; or 4) call 911 and ask to speak to the mental health worker on call.

- According to the laws in many states and all professional ethics codes, any kinds of sexual conduct or asking for sexual conduct, or sexual misconduct by a mental health provider with a client is illegal, as well as unethical.

Initial Intake/Evaluation

- The purpose of the intake process is to fully evaluate your needs and ensure you receive the best treatment possible. The evaluation itself may vary across clients and may include activities such as completing a structured interview (i.e., every client is asked the same questions to ensure comprehensiveness), questionnaires, or several other options.

- By the end of this intake period (first 1-2 sessions), I will be able to offer you an initial impression of your needs and a plan for what treatment might include if you decide to continue with therapy. If we are unable to work together, I will provide you with a list of referrals.

Scope of My Services

- I am qualified to work with a wide variety of clients and problems, but sometimes I may not have the training needed to address a particular concern. If this is the case, I will discuss it with you and make sure that you receive a referral to another professional who is better qualified to serve you.

- Also, if you are having current hallucinations/ delusions, severe thoughts of suicide or self- harm, or extreme mood swings, you may need more support than I can offer you through weekly psychotherapy, and I reserve the right to refer you to a different or more intensive treatment if I believe you exceed the level of care I can offer.

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. 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. However, there are limits to this confidentiality that you should know about.

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to the legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Pinnacle Health Services

Pinnacle Health Services
547 E Pine Street, Suite 201
Phone (541) 423-8151 Fax (541)
423-8508

Therapy Agreement Continued…

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/ or legal authorities.

Minors/ Guardianship

Parents or legal guardians of non-emancipated minor clients may have the right to inspect the clients records unless the health care provider determines that access to the client's record would have a detrimental effect on the providers' professional relationship with the minor client, or the minor's physical safety or psychological wellbeing.

GENERAL CONSENT TO DO PSYCHOTHERAPY

- I have read and fully understand these client policies and give my full-informed consent.
- I apply for and consent to psychotherapy with Dr. Kacy Mullen,PhD, Leslie Rheault, LPC , Shannon Modjeski, LPC, Bronson Dull, LCSW
- I further understand that I am responsible for payment even though my insurance company may or may not reimburse me at a later time.
- I understand any conversations over five (5) minutes in duration will be charged in fifteen (15) minute increments.

_____ _____

Client Signature Date

_____ _____

Parent or Guardian Date

Pinnacle Health Services

Pinnacle Health Services

547 E Pine Street, Suite 201
Phone (541) 423-8151 Fax (541) 423-8508

Scheduling Agreement

Welcome to Pinnacle Health Services. We look forward to partnering with you in your care. It is our priority to make our clinic an environment where patients will receive the highest quality of professional care. The providers with Pinnacle Health Services are committed to maintaining a cooperative and effective relationship with their patients who have entrusted their care with us. Please review the scheduling conditions below.

❖ Coordination of care

- Should my care **lapse for 30 days** or more between sessions without my provider's recommendation, I will be transitioned to an inactive patient status.
- I understand that I can resume my care at any time but may be asked to re-establish with my provider depending on the length of absence.

❖ Scheduling

- I understand that I am responsible for scheduling and rescheduling my appointments.
- I understand that appointments cannot be scheduled for **more than 1 month in advance** without my provider's recommendation.
- I understand that should I reschedule often, even with notice; I may be limited to how many appointments can be scheduled at a time and/or be limited to scheduling too far in advance.

❖ No-Show/Late Cancellation Policy

- Should I need to cancel or reschedule my appointment, I understand I am required to give Pinnacle Health Services a full **48 hours' notice**.
- I understand that should I not give 48 hours' notice; my cancellation may be considered a late cancellation or no notice occurrence.
- I understand that a late cancellation or no notice appointment *may* incur a fee of $50 per occurrence.
- I understand that I am limited to **3** no notice or late cancellations before I will be **discharged** from Pinnacle Health Services.

❖ Payment Authorization

- I give permission to Pinnacle Health Services to hold my credit card on file and authorize automatic payments should I incur any cancelation/no show fees.
  - I have given the **credit card ending in:** _____ **(last 4)** and agree to maintain a valid card on file as long as I remain an active patient.

- I understand my card will be charged on the same day as the occurrence.

Please read the following statements and initial:

_____After 2 statements are sent out (60 days) without payment of fees, the patient will be sent to in-house collections and must pay balance before being allowed to reschedule follow-up appointments.

_____ If patient arrives more than 10 minutes late for a follow up appointment patient is unable to be seen and will be charged as a "No-Notice/No-Show" occurrence. Late arrivals for a follow up appointments may be subject to a $50 fee.

My signature acknowledges that I understand and agree to the terms listed above. I understand my responsibility as a patient with Pinnacle Health Services.

Printed Name _____ _____

Date

Signature: _____

Pinnacle Health Services Screening Questionnaire*

Name: _____

In order to help you move forward in the direction you would like to be going in your life, we would appreciate learning more about what problems or difficulties you might be experiencing as well as what you would like to see change in your life.

Over the ***last two weeks***, how often have you been bothered by any of the following problems?
(please circle your answer & **check the boxes that apply to you**)

	Not at all	Several days	More than half the days	Nearly Every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. ☐ Trouble falling or staying asleep, or ☐ sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. ☐ Poor appetite or ☐ overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. ☐ Moving or speaking so slowly that other people could have noticed, or ☐ the opposite - being so fidgety or restless that you've been moving around a lot more than usual	0	1	2	3
9. ☐ Thoughts that you would be better off dead, or ☐ hurting yourself in some way	0	1	2	3
(10)		add columns:			**Total**

1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
(8)		add columns:			**Total**

*adapted from PhQ 9, GAD7, PC-PTSD and AUDIT 1/24/11

Please also complete back side →

Are you currently in any physical pain?	No	Yes

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, ***in the past month***, you:

1. Have had nightmares about it or thought about it when you did not want to?	No	Yes
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	No	Yes
3. Were constantly on guard, watchful, or easily startled?	No	Yes
4. Felt numb or detached from others, activities, or your surroundings?	No	Yes

What are the top 1-3 things you would like to see change in your life right now?

1. _____
2. _____
3. _____

What are the most important reasons why you want to make the changes above?

What goals would you like to work on with a counselor/therapist, if any?

Thank you for taking the time to complete this questionnaire. We look forward to working with you on your goals!