Hockanum Valley Community Council, Inc.

Child/Teen Intake Questionnaire

Parents, in order for us to be able to fully evaluate your child or teenager, please fill out the following intake form and questionnaire to the best of your ability. We realize there is a lot of information and you may not remember or have access to all of it; Do the best you can. If there is information you do not want in your child or teenager's medical chart, it is okay to refrain from including that information. Thank you!

PATIENT IDENTIFICATION

Name _____ First Appointment Date _____
Birth Date _____ Age _____ Sex_____
School _____ Grade _____ Soc. Sec. # _ _ _-_ _ - _ _ _ _
Mother's Name _____ Father's Name _____
Race _____
Address _____
City _____ State _____ Zip _____
Home Phone # _____ Parent Work# _____ (specify) Mom or Dad
Who is the child currently living with? _____
(If applicable)Legal Guardian Name: _____
Address: _____ Phone # _____

INSURANCE INFORMATION: (Please present your insurance cards to receptionist)

Primary Ins. Co _____ Policy/ID # _____ Grp # _____
Policy Holder's Name: _____ Policy Holder's SS# _____
Policy Holder's DOB _____

Secondary Ins. Co _____ Policy/ID # _____ Grp # _____
Policy Holder's Name: _____ Policy Holder's SS# and DOB _____

REFERRAL SOURCE

Referral Source _____
Referral Address _____ Phone # _____
Do we have your permission to release information to the referring professional when it is appropriate?
Yes _____ No _____ (If yes, please complete the attached Authorization Form)

MAIN PURPOSE OF THE CONSULTATION (Please give a brief summary of the main problems)

WHY DID YOU SEEK THE EVALUATION AT THIS TIME?
What do you want this clinic to do for the child, yourself, or your family?

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PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR PSYCHIATRIC HISTORY
(Please include contact with other professionals, medications, types of treatment, etc.)

MEDICAL HISTORY
Current medical problems/medications:_____
Other doctors/clinics seen regularly: _____
History of head trauma? (describe): _____
Ever any seizures or seizure-like activity? _____
Any periods of spaciness or confusion? _____
Prior hospitalizations (place, cause, date, outcome): _____
Allergies/drug tolerances (describe): _____
Present Height _____ *Present Weight* _____

Current Stresses (Please list current factors that are a source of stress in the family)

FAMILY HISTORY
Family Structure (who lives in the current household with the child. Please give relationship to the child):

Current Marital Situation/Satisfaction of Parents _____

Family Development (include marriages, separations, divorces, deaths, traumatic events, losses. etc.)

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Separations from mother and/or father: Age, duration, reaction to

_____

_____

_____

Siblings Names, ages, problems, strengths, relationship to patient)

_____

_____

_____

_____

School History: Current Grade _____ School Conduct_____
Number of schools attended _____ Average Grades _____
Homework Problems _____
Specific Learning Disabilities _____
Strengths _____

Has child been suspended from school? _____

Please bring school report cards and any state, national, or special testing that has been performed.

Legal History:
Is child on Probation/Parole: _____ (If yes, Please provide name and phone number of P.O)
P.O. _____
Telephone Number _____

Is the child facing Current Charges? _____ (If yes, what is the charge(s) _____
_____

Has the child been arrested before? _____ (If yes, for what charges) _____
_____

Overall Strengths – as viewed by the parents

_____

_____

_____

Overall Strengths – as viewed by the child/teen

_____

_____

_____

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Cancellation, Missed Appointment and Fee Policies

FEES:
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CANCELLATION:
It is the policy of HVCC that clients call and notify us at least twenty-four (24) hours in advance if they intend to cancel their scheduled appointment. Failure to adhere to this policy will result in the client being charged their normal and customary fee for the missed appointment. This fee, along with their regular fee, must be paid the next time the client comes to HVCC for counseling.

MISSED APPOINTMENTS:

1. If a client misses a scheduled appointment without calling to cancel, the client will be charged the normal and customary fee for the missed appointment, payable their next visit to HVCC.

2. When an appointment is missed, your therapist will send you a letter. If you do not respond within two weeks, services will be stopped and you cannot request further services for at least three (3) months with approval of your therapist unless you have a psychiatric emergency.

3. Two missed appointment in a row: services are stopped. You will be informed of such in writing and cannot request further services for at least three (3) months unless there is a psychiatric emergency.

4. Three missed or cancelled appointments within five (5) scheduled visits. Services will be stopped and you will be informed of such in writing. You cannot request renewed services for three (3) months unless there is a psychiatric emergency.

If you or your family is involved with services of the Department of Children and Families, Town Social Services, Family Relations, Probation or Parole, we will inform them of service termination due to missed or cancelled appointments.

Client Rights Statement

Hockanum Valley Community Council, Inc. is a multi-service agency, which provides a broad range of social services to the Tri-Town Area. These services include counseling/case management services to individuals, families and youth, outreach services, transportation services, emergency food and clothing, summer youth employment and intake for the energy assistance and commodities programs. As a facility providing counseling/mental health services, it is our responsibility to provide each of our clients with information regarding their rights as established by Connecticut General Statute #306. Although the language and emphasis of this statute may not be applicable to many clients of some programs of HVCC, it is the intention of this law to convey to all recipients of health and social services that they are entitled to specialized, quality care.

Records are confidential, and released only with the client's written permission, except under the following circumstances:

1. Subpoenaed under court order.
2. Review by public and private accrediting, funding and monitoring bodies.
3. Situations that are potentially life threatening to self or others, including situations involving child abuse and/or neglect.

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Please Read and Sign Below:

I have read the above Cancellation, No Show, and Fee policy of HVCC. I understand and agree to abide by it while I am receiving the services of Hockanum Valley Community Council,
Inc.

I, _____, have received a copy of the above **Client's Right's** form, and the a copy of Chapter #306 **Department of Health , Patients Rights**. I have discussed and do understand this document.

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Program

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CONSENT AND ACKNOWLEDGMENT FORM

I consent to the use or disclosure of my protected health information by HockanumValley Community Council, Inc. (HVCC) to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information used or disclosed by HVCC may include HIV/AIDS related information, psychiatric and other mental health information and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how HVCC will use and disclose my information can be found in HVCC's Notice of Privacy Practices. I understand that this consent is effective for as long as HVCC maintains my protected health information.

By signing below, I understand and acknowledge the following:

- I have read and understand this consent; and
- I have received HVCC's Notice of Privacy Practices currently in effect

_____
Print Name of Individual or Personal Representative

_____ _____
Signature of Individual or Personal Representative (Parent/Guardian) Date

If signed by the individual's representative, describe the legal authority of the representative to act on behalf of the individual: _____

Unable to obtain written consent and acknowledgment because:

- ❑ Individual refused
- ❑ Emergency treatment situation
- ❑ Individual not able to sign due to incompetence or other medical reason
- ❑ Other: _____

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DEPARTMENT OF HEALTH SERVICE
Hospital and Medical Care Division
Mental Health Facilities Licensure Section

PATIENTS' RIGHTS

Chapter 3306

Sections 17-206 b,c,d,e,j,k

Section 17-206b. Deprivation of rights of patient prohibited. Exception

No patient treated in any public or private facility for the treatment of the mentally disordered shall be deprived of any personal property or civil rights, including the right to vote, hold or convey property, and contract except in accordance with due process of law, and unless he/she has been declared incompetent pursuant to chapter 779. Any finding of incompetence shall specifically state which civil or personal rights the patient is incompetent to exercise.

Section 17-206c. Humane and dignified treatment required.

Every patient treated in any facility for treatment of the mentally disordered shall receive personal dignity and right to privacy. Each patient shall be treated in accordance with a specialized treatment plan suited to his/her disorder.

Section 17-206d. Procedures governing medication and treatment.

(a) Voluntary patients may receive medication or treatment, but shall not be forced to accept unwanted medication or treatment, except in accordance with procedures set forth in subsection (b) of this section. No medical intervention may be undertaken without the patient's written informed consent, except in accordance with subsection (b) of this section.

(b) If the head of the facility, in consultation with a physician, determines that the condition of a patient, either voluntary or involuntary, of an extremely critical nature, then emergency measures may be taken without the consent otherwise provided for in this section.

(c) No public or private facility shall request or require blanked consent to all procedures as a condition of admission or treatment.

Section 17-206e. Medication not be used as substitute for habilitation.

(a) Medication shall not be used as a substitute for a habilitation program.

Section 17-206j. Denial of employment, housing, licenses, because of history of mental disorder restricted.

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(a) No person shall be denied employment, housing, civil service rank, any license or permit, including a professional license, or any other civil or legal right, solely because of a present or past history of mental disorder except as so provided by the general statutes.

(b) The burden shall be on the person or agency denying any such right to prove that the person so denied is not suitable solely because of his/her present or past history of mental disorder.

Section 17-206k. Remedies of aggrieved persons.

Any person aggrieved by a violation of sections 17-206a to 17-206j, inclusive, may petition the superior court within whose jurisdiction the person is or resides for appropriate relief, including temporary and permanent injunctions, or may bring a civil action for damages.

Addendum: Section 17-206a: Definitions.

As defined in Section 17-206 a, b, c, d, e, f, j, k inclusive:

Section 17-206a. Definitions. When used in sections 17-206a to 17-206k, inclusive, unless otherwise expressly stated or unless the context otherwise requires:

a) "Facility" means any inpatient or outpatient hospital, clinic, or other facility for the diagnosis, observation or treatment of the mentally disordered;
b) "Patient" means any person being treated in a facility;
c) "The Mentally disordered" means those children and adults who are suffering from one or more mental disorders as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorder";
d) "Family" means spouse or next to kin;
e) "Head of the hospital" or "head of the facility", means the superintendent or medical director of a hospital or a facility, or his/her designated delegate;
f) "Informed consent" means permission given on the basis of knowledge of the implications, consequences or possible complications of affects of such permission;
g) "Medically harmful" means capable of inflicting serious mental or physical injury on the patient, or producing in the patient a disturbed mental state or impaired judgment which may be grossly detrimental to his/her physical or mental well being.

Criteria for Involuntary Termination:

Any mental health services client will be involuntarily terminated if:
a) The client comes to sessions under the influence of drugs or alcohol.
b) The client becomes threatening or assaultive.
c) The client has the ability to pay the established fee and has not paid for two consecutive sessions, or has an ongoing pattern of non-payment.
d) The client misses two (2) consecutive appointments without arranging with the Therapist.

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1. Subpoenaed under court order.
2. Review by public and private accrediting, funding and monitoring bodies.
3. Situations that are potentially life threatening to self or others, including situations involving child abuse and/or neglect.

I, _____ , have received a copy of this form, and the attached copy of Chapter #306. I have discussed and do understand this document.

_____ _____
Client Signature Date

_____ _____
Witness Program

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