Willamette Health & Wellness, LLC

Intake Packet for Adolescent
(12 to17 years of age)

This packet includes:

- Personal History Questionnaire
- Office Policy and HIPAA privacy notices signature page. (you do not have to print this out)
- Signature Page

Link to insurance page: http://willamettehealthandwellness.com/insurance/

If using insurance, call your insurance provider to verify coverage

Questions to ask your insurance company prior to your first visit:

- Is Provider's name a part of my behavioral health *preferred provider* (PP) network?
  - If not a PP: Does my policy included *out of network* (OON) benefits?
  - What are my OON benefits?
- What is my PP or out of network *co-pay*/*co-insurance* and *deductible*?
  - If yes to *deductible*: What amount still needs to be satisfied?
  - What is a deductible?
  - To whom do I pay my deductible?
- Does my policy require *authorization*s?
  - If yes: How do I get the *authorization*(s)?
- Does my policy have *limitations*?
  - If yes: What are my limitations?

Link to fee schedule: http://willamettehealthandwellness.com/fee-schedule/

Come prepared for your appointment
Patients with incomplete paperwork may be asked to reschedule

Check List

- Bring the completed Personal History Questionnaire
- ☐ Read the office policies and HIPAA privacy notice
- ☐ Bring completed the signature page.
- ☐ Check our website for address and parking instructions

http://willamettehealthandwellness.com/wp-content/uploads/2013/10/WHW-parking-guide-2016_2_4.pdf

- ☐ Bring medical history information if you feel it would be beneficial
- ☐ Bring insurance card (if using insurance)
- ☐ Bring method of payment (cash, check or debit/credit card)
- ☐ Arrive 10 minutes early

Willamette Health & Wellness, LLC

Personal History Questionnaire: Parent/Guardian (adolescent's information)

GENERAL **Today's Date:** / / **Form Completed by:**

I am related to patient through: ☐Birth ☐Adoption ☐Fostering ☐ Other:			
Patient Name:	DOB: / /	Age:	Gender:
Primary Address:	City:	State:	Zip:
Patient Telephone: (home): ( ) -	(cell): ( ) -		
Guardian 1: Name:	Relationship to patient: ☐Mother ☐Father ☐Other:		
☐Address Same as Patient Primary Address			
Primary Address:	City:	State:	Zip:
Telephone: (home): ( ) - (leave blank if same as patient)	(work): ( ) -	(cell): ( ) -	
May we leave a message for you at home? ☐Yes ☐No	At work? ☐Yes ☐No	On cell? ☐Yes ☐No	
May we contact you by email? Email: @	How did you hear about me/us?		
Guardian 2: Name:	Relationship ☐Mother ☐Father ☐Other:		
☐Address Same as Patient Primary Address:			
Primary Address:	City:	State:	Zip:
Telephone: (home): ( ) - (leave blank if same as patient)	(work): ( ) -	(cell): ( ) -	
May we leave a message for you at home? ☐Yes ☐No	At work? ☐Yes ☐No	On cell? ☐Yes ☐No	
May we contact you by email? Email: @			
Alternative Emergency Contact :	Relationship:	Phone: ( ) -	
Preference for appointment reminders: (choose one) ☐Email: @ ☐Call: ( ) - ☐Text: ( ) -			
Name of Current therapist/ psychiatric provider:	Phone number: ( ) -		

Please provide the names, ages and relationship of those living with the patient		
Name	Age	Relationship to patient?

Please list names and ages of any siblings of the patient not living with the patient:

REASON(S) FOR VISIT

Describe your reason for the patient attending this appointment:

Describe any recent changes that may contribute to this issue:

Why do you think the patient have this issue?

When did the patient first experience this issue?

MENTAL HEALTH/PSYCHIATRIC HISTORY

Please mark any symptoms you believe the patient experiences (C)urrently or in the (P)ast.

C	P		C	P		C	P	
☐	☐	depressed/sad mood	☐	☐	muscle tension	☐	☐	relationship problems
☐	☐	reduced interest in activities	☐	☐	excessive worry	☐	☐	eating problems
☐	☐	appetite/weight change	☐	☐	panic symptoms	☐	☐	drug or alcohol problems
☐	☐	frequent crying/tearfulness	☐	☐	boredom	☐	☐	gambling problems
☐	☐	low self-esteem	☐	☐	impulsivity	☐	☐	sexual problems
☐	☐	low motivation	☐	☐	distractibility	☐	☐	computer addiction
☐	☐	social isolation	☐	☐	hyperactivity	☐	☐	problems with pornography
☐	☐	feelings of hopelessness	☐	☐	abnormally elevated mood for	☐	☐	work/school problems
☐	☐	seasonal mood changes			several uninterrupted days	☐	☐	parenting problems
☐	☐	loneliness	☐	☐	racing thoughts	☐	☐	suspiciousness/paranoia
☐	☐	feelings of guilt/shame	☐	☐	excessive energy	☐	☐	hearing or seeing things
☐	☐	sleeping too much or too little	☐	☐	flashbacks	other:		
☐	☐	low energy/fatigue	☐	☐	nightmares	other:		
☐	☐	excessive thoughts of death	☐	☐	easily startled	other:		
☐	☐	poor concentration	☐	☐	anger outbursts	other:		
☐	☐	restlessness or feeling on edge/keyed up	☐	☐	excessive fears	other:		
☐	☐	difficulty thinking or making decisions	☐	☐	excessive social discomfort			
☐	☐	irritability	☐	☐	obsessions/compulsions			
☐	☐	frequent anxiety	☐	☐	fear away from home			

Are any of the above symptoms affecting the patients'?
☐ability to engage in normal daily activities ☐work ☐school ☐housing ☐finances ☐recreational activities ☐legal status ☐relationships ☐ health ☐happiness ☐spirituality ☐self esteem ☐sexual activity

Has the patient been diagnosed with mental health/psychiatric problems in the past? ☐Yes ☐No

Diagnosis	Dates treated or age	By whom

Please list medications the patient has previously taken for mental health reasons.

Name of medication	How long did he/she take?	Dosage	Usefulness/Side Effects/Concerns

Has he/she been psychiatrically hospitalized? ☐Yes ☐No When?

Why?

Has he/she ever attempted suicide? ☐Yes ☐No When? How?
Has he/she ever engaged in self-harm behavior? ☐Yes ☐No When? How?

Please note presence of family history of mental health problems:			
	Relationship to patient	Age of diagnosis?	Treatment?
☐ Depression			
☐ Anxiety			
☐ Schizophrenia			
☐ Bipolar (manic/depression)			
☐ Post-traumatic stress disorder			
☐ Alcohol abuse			
☐ Other substance abuse			
☐ ADHD/ADD			
☐ Suicide or attempted suicide			
☐ Other, specify:			

GENERAL HEALTH/MEDICAL HISTORY

Primary Care Provider (PCP) Name:		
PCP Address:	Phone: ( ) -	FAX: ( ) -
Approximate Date of Last Visit:	Reason for Visit:	
Allergies to Medication:	Allergies to Other:	
Please list any ongoing medical problems he/she has:		

Please list any other outpatient mental health treatment (e.g. therapy, medication management by PCP, medication management by psychiatric provider).		
Name/Place	Approximate Dates	Outcome/Experience
	-	
	-	
	-	
	-	

Please list all current prescription medications, over the counter medications, herbal remedies, nutritional supplements:			
Name of Medication/Supplement	Dosage/ Frequency	Purpose	Prescribing/Recommending Provider's Name

Review of Systems:

Below please check any of the following health problems that you are aware that the patient is <u>currently</u> experiencing or has experienced in the last three months.

General	☐ Sores that won't heal	**Vascular**
☐ Weight loss or gain	**Neck**	☐ Pain in lower leg when walking
☐ Fatigue	☐ Lumps	☐ Leg cramping
☐ Fever or chills	☐ Swollen glands	**Musculoskeletal**
☐ Weakness	☐ Pain	☐ Muscle or joint pain
☐ Trouble sleeping	☐ Stiffness	☐ Stiffness
Skin	**Breasts**	☐ Back pain
☐ Rashes	☐ Lumps	☐ Redness of joints
☐ Lumps	☐ Pain	☐ Swelling of joints
☐ Itching	☐ Discharge	☐ Trauma
☐ Dryness	☐ Breast feeding (if applicable)	**Neurologic**
☐ Color changes	**Respiratory**	☐ Dizziness
☐ Hair and nail changes	☐ Cough	☐ Fainting
Head	☐ Sputum	☐ Seizures
☐ Headache	☐ Coughing up blood	☐ Weakness
☐ Head injury	☐ Shortness of breath	☐ Numbness
☐ Neck pain	☐ Wheezing	☐ Tingling
Ears	☐ Painful breathing	☐ Tremor
☐ Decreased hearing	**Cardiovascular**	☐ Memory loss
☐ Ringing in ears	☐ Chest pain or discomfort	☐ Incoordination
☐ Earache	☐ Tightness	☐ Feeling of restlessness in legs, especially at night
☐ Drainage	☐ Palpitations	
Eyes	☐ Shortness of breath with activity	☐ Feelings of internal restlessness made worse by medication
☐ Vision loss/change	☐ Difficulty breathing lying down	
☐ Glasses or contacts	☐ Swelling	☐ Involuntary movements of the tongue, lips, mouth
☐ Pain	☐ Sudden awakening from sleep with shortness of breath	
☐ Redness		☐ Involuntary movements of other parts of body. Which ones?
☐ Blurry or double vision	**Gastrointestinal**	
☐ Flashing lights	☐ Swallowing difficulties	☐ Hyper reflexes
☐ Specks	☐ Heartburn	**Hematologic**
☐ Glaucoma	☐ Change in appetite	☐ Bruise easily
☐ Cataracts	☐ Nausea	☐ Bleed easily
Nose	☐ Change in bowel habits	**Endocrine**
☐ Stuffiness	☐ Rectal bleeding	☐ Heat or cold intolerance
☐ Discharge	☐ Constipation	☐ Hot flashes
☐ Itchiness	☐ Diarrhea	☐ Frequent urination
☐ Hay fever	☐ Yellow eyes or skin	☐ Excessive thirst
☐ Nosebleeds	☐ Abdominal Pain	☐ Change in appetite or weight
☐ Sinus pain	**Urinary**	☐ Night sweats
Mouth/Throat	☐ Frequency	☐ Excessive sweating
☐ Bleeding	☐ Urgency	**Other**
☐ Dentures	☐ Burning or pain	☐
☐ Sore tongue	☐ Blood in urine	☐
☐ Dry mouth	☐ Incontinence	☐
☐ Sore throat	☐ Change in urinary strength	☐
☐ Hoarseness	☐ Frequent night time waking to urinate. How often?	☐
☐ Thrush		☐

Please check any of the following health problems that the patient currently has, has had in the past, or that family members have had. (Please include parents, siblings, children, aunts/uncles, grandparents)

	History? ✓	Current? ✓	Family History? ✓	Relationship to the patient?
Anemia	☐	☐	☐	
Asthma	☐	☐	☐	
Cancer	☐	☐	☐	
Chronic Pain	☐	☐	☐	
Diabetes	☐	☐	☐	
Head Injury	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
High Cholesterol	☐	☐	☐	
HIV+	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Liver Disease (including hepatitis)	☐	☐	☐	
Seizures/Epilepsy	☐	☐	☐	
Stomach/GI Problems	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Other, Specify:	☐	☐	☐	
Other, Specify:	☐	☐	☐	

Does the patient exercise at least once a week? ☐Yes ☐No How often?
What kind of exercise?

Describe what the patient ate yesterday:

Do you have any worries about the patient's eating habits?

What do you think the patient thinks about his/her weight and shape?

Has the patient ever binged, purged, over exercised or significantly restricted caloric intake for managing weight or body image?
☐Yes ☐No If yes, please describe:

What strategies does he/she use for stress management?

What activities does he/she enjoy?

Substance used current or past…	First Use?	How Much?	How Often?	Last Use?	Consequences of use? Tolerance, withdrawal, legal or relationship consequences?	Has it ever been a problem?
Caffeine						
Tobacco						
Alcohol						
Drugs Type:						
Medications not prescribed to you? Type:						

ADDICTION/RECOVERY

Has the patient experienced problems (past or present) with any of the following? ☐Alcohol ☐Drugs ☐Gambling ☐Sex/Love Addiction ☐Food ☐Loved one's Addictions ☐Other: _____ ☐None If you marked "None" Please skip to next section.
Please briefly describe the patient's addiction history:

Would you describe the patient as currently "in recovery"? ☐ Yes ☐ No	How Long?
Use of 12 Step Program? ☐ Yes ☐ No	Another Recovery Program? ☐ Yes ☐ No List:

Please describe nature of his/her recovery:

PREGNANCY/BIRTH/DEVELOPMENT

Known substance/toxin exposure patient may have experienced in utero? ☐ Cigarettes ☐ Alcohol ☐ Drugs-List: Other:	
List any complications during delivery:	Type of delivery: ☐ Vaginal ☐ C-section
Birth weight:	Gestational age at birth:
Did mother experience "baby blues" (postpartum depression)? ☐ Yes ☐ No	
If yes, did mother seek treatment? ☐ Yes ☐ No If Yes, describe:	

Describe any prolonged separation from parent(s) during infancy:
Did he/she meet his/her developmental milestones on time? ☐ Yes ☐ No If No, describe:

SOCIAL/FAMILY HISTORY

Where was he/she born, and raised?	By Whom?
The patient's current relationship with siblings?	Describe your current relationship with the patient?
Did anyone else live in the patient's home other than parents and siblings? ☐ Yes ☐ No If so whom?	
Describe any concerns you have about his/her social skills or behavior:	
What are his/her current favorite activities?	
Please indicate how many hours a day he/she spends on: TV: Computer: Videogames: Other screens:	
Where does he/she child live? ☐House ☐ Apartment	
Describe the household: ☐ Messy ☐ Chaotic ☐ Orderly	How much variation in his/her day? ☐ A little ☐ A lot ☐ Varies
How many times has he/she moved?	
Is the current neighborhood kid friendly? ☐ Yes ☐ No	If no, why not?
Family support comes from: ☐ Extended family ☐ Neighbors ☐ Church ☐ Friends ☐ Counselor ☐Other:	
Describe any household chores/duties chld is he/she responsible for:	
Who is the primary disciplinarian?	
Is discipline consistent? ☐ Yes ☐ No If No why not?	
Describe form of discipline used at home: Patient's response:	

Please check any environmental factors present during the patient's life:

☐Parental divorce/separation	☐Death in the family	☐Parental illness

☐ Frequent moves	☐ Unemployment of parent(s)	☐ Financial stress
☐ Family member disability	☐ Crime victim	☐ Emotional abuse
☐ Physical abuse	☐ Sexual abuse	☐ Violence in home
☐ Substance abuse by self/parent	Other:	Other:

Please list any legal history he/she has (arrests, convictions, lawsuits, DHS involvement, parental custody, guardianship): ☐ None
Describe:

Please describe patient's educational experience:

Enrolled in school? ☐ Yes ☐ No If 'no' why not?

Current School: Grade:

How does he/she do in school (socially & academically)?

Are there any problems going on at school? ☐ Yes ☐ No Describe:

Please describe his/her ethnic, cultural, and/or religious/spiritual background:

Please describe any further concerns/issues not addressed elsewhere in this questionnaire:

Please describe outcomes you would like for the patient from this visit/treatment from this provider.

Willamette Health & Wellness, LLC

Personal History Questionnaire: To be completed by Adolescent

GENERAL **Today's Date:** / /

Name:	DOB: / /	Age:	Gender:
Address:	City:	State:	Zip:
Telephone: (home): ( ) -	(cell): ( )- -		
May I leave a message for you at home? ☐ yes ☐ no	At cell? ☐ yes ☐ no		
May I contact you by email? If so, email: @	How did you hear about me/us?		
Preference for appointment reminders: ☐Email: @ ☐Call: ( ) - ☐Text: ( ) -			

Please provide the names, ages and relationship of those living with you.

Name	Age	Relationship to you?

Please list names and ages of any siblings not living with you:

REASON(S) FOR VISIT

Describe why you are attending this appointment:

Describe any recent changes that may contribute to this issue:

When did you first experience this issue?

MENTAL HEALTH/PSYCHIATRIC HISTORY

Please mark any symptoms you have experienced (C)urrently or in the (P)ast.

C	P		C	P		C	P	
☐	☐	depressed/sad mood	☐	☐	muscle tension	☐	☐	relationship problems
☐	☐	reduced interest in activities	☐	☐	excessive worry	☐	☐	eating problems
☐	☐	appetite/weight change	☐	☐	panic symptoms	☐	☐	drug or alcohol problems
☐	☐	frequent crying/tearfulness	☐	☐	boredom	☐	☐	gambling problems
☐	☐	low self-esteem	☐	☐	impulsivity	☐	☐	sexual problems
☐	☐	low motivation	☐	☐	distractibility	☐	☐	computer addiction
☐	☐	social isolation	☐	☐	hyperactivity	☐	☐	problems with pornography
☐	☐	feelings of hopelessness	☐	☐	abnormally elevated mood for	☐	☐	work/school problems
☐	☐	seasonal mood changes			several uninterrupted days	☐	☐	parenting problems
☐	☐	loneliness	☐	☐	racing thoughts	☐	☐	suspiciousness/paranoia
☐	☐	feelings of guilt/shame	☐	☐	excessive energy	☐	☐	hearing or seeing things
☐	☐	sleeping too much or too little	☐	☐	flashbacks	other:		
☐	☐	low energy/fatigue	☐	☐	nightmares	other:		
☐	☐	excessive thoughts of death	☐	☐	easily startled	other:		
☐	☐	poor concentration	☐	☐	anger outbursts	other:		
☐	☐	restlessness or feeling on edge/keyed up	☐	☐	excessive fears	other:		
☐	☐	difficulty thinking or making decisions	☐	☐	excessive social discomfort			
☐	☐	irritability	☐	☐	obsessions/compulsions			
☐	☐	frequent anxiety	☐	☐	fear away from home			

Are any of the above symptoms affecting your:

☐ability to engage in your normal daily activities ☐work ☐school ☐housing ☐finances ☐recreational activities ☐legal status ☐relationships ☐health ☐happiness ☐spirituality ☐self esteem ☐sexual activity

Have you been diagnosed with mental health/psychiatric problems in the past? ☐Yes ☐No

Diagnosis	Dates treated or age	By whom

Please list medications you have previously taken for mental health reasons.

Name of medication	How long did you take?	Dosage	Usefulness/Side Effects/Concerns

Have you been psychiatrically hospitalized? ☐Yes ☐No When? Why?
Have you ever attempted suicide? ☐Yes ☐No When? How?
Have you ever engaged in self-harm behavior? ☐Yes ☐No When? How?

GENERAL HEALTH/MEDICAL HISTORY

Allergies to Medication:	Allergies to Other:

Please list any other outpatient mental health treatment (e.g. therapy, medication management by PCP, medication management by psychiatric provider).

Name/Place	Approximate Dates	Outcome/Experience
	-	
	-	
	-	
	-	

Please list any ongoing medical problems you have:

Please list all current prescription medications, over the counter medications, herbal remedies, nutritional supplements:

Name of Medication/Supplement	Dosage/ Frequency	Purpose	Prescribing/Recommending Provider's Name

Review of Systems:

Below please check any of the following health problems that you <u>currently</u> experiencing or have experienced in the last three months.

General	☐ Sores that won't heal	**Vascular**
☐ Weight loss or gain	**Neck**	☐ Pain in lower leg when walking
☐ Fatigue	☐ Lumps	☐ Leg cramping
☐ Fever or chills	☐ Swollen glands	**Musculoskeletal**
☐ Weakness	☐ Pain	☐ Muscle or joint pain
☐ Trouble sleeping	☐ Stiffness	☐ Stiffness
Skin	**Breasts**	☐ Back pain
☐ Rashes	☐ Lumps	☐ Redness of joints
☐ Lumps	☐ Pain	☐ Swelling of joints
☐ Itching	☐ Discharge	☐ Trauma
☐ Dryness	☐ Breast feeding (if applicable)	**Neurologic**
☐ Color changes	**Respiratory**	☐ Dizziness
☐ Hair and nail changes	☐ Cough	☐ Fainting
Head	☐ Sputum	☐ Seizures
☐ Headache	☐ Coughing up blood	☐ Weakness
☐ Head injury	☐ Shortness of breath	☐ Numbness
☐ Neck pain	☐ Wheezing	☐ Tingling
Ears	☐ Painful breathing	☐ Tremor
☐ Decreased hearing	**Cardiovascular**	☐ Memory loss
☐ Ringing in ears	☐ Chest pain or discomfort	☐ Incoordination
☐ Earache	☐ Tightness	☐ Feeling of restlessness in legs, especially at night
☐ Drainage	☐ Palpitations	
Eyes	☐ Shortness of breath with activity	☐ Feelings of internal restlessness made worse by medication
☐ Vision loss/change	☐ Difficulty breathing lying down	
☐ Glasses or contacts	☐ Swelling	☐ Involuntary movements of the tongue, lips, mouth
☐ Pain	☐ Sudden awakening from sleep with shortness of breath	
☐ Redness		☐ Involuntary movements of other parts of body. Which ones?
☐ Blurry or double vision	**Gastrointestinal**	
☐ Flashing lights	☐ Swallowing difficulties	☐ Hyper reflexes
☐ Specks	☐ Heartburn	**Hematologic**
☐ Glaucoma	☐ Change in appetite	☐ Bruise easily
☐ Cataracts	☐ Nausea	☐ Bleed easily
Nose	☐ Change in bowel habits	**Endocrine**
☐ Stuffiness	☐ Rectal bleeding	☐ Heat or cold intolerance
☐ Discharge	☐ Constipation	☐ Hot flashes
☐ Itchiness	☐ Diarrhea	☐ Frequent urination
☐ Hay fever	☐ Yellow eyes or skin	☐ Excessive thirst
☐ Nosebleeds	☐ Abdominal Pain	☐ Change in appetite or weight
☐ Sinus pain	**Urinary**	☐ Night sweats
Mouth/Throat	☐ Frequency	☐ Excessive sweating
☐ Bleeding	☐ Urgency	**Other**
☐ Dentures	☐ Burning or pain	☐
☐ Sore tongue	☐ Blood in urine	☐
☐ Dry mouth	☐ Incontinence	☐
☐ Sore throat	☐ Change in urinary strength	☐
☐ Hoarseness	☐ Frequent night time waking to urinate. How often?	☐
☐ Thrush		☐

Please check any of the following health problems that you currently have, have had in the past, or that family members have had. (Please include parents, siblings, children, aunts/uncles, grandparents)

	Past history? ✓	Current? ✓	Family History? ✓	Relationship to you?
Anemia	☐	☐	☐	
Asthma	☐	☐	☐	
Cancer	☐	☐	☐	
Chronic Pain	☐	☐	☐	
Diabetes	☐	☐	☐	
Head Injury	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
High Cholesterol	☐	☐	☐	
HIV+	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Liver Disease (including hepatitis)	☐	☐	☐	
Seizures/Epilepsy	☐	☐	☐	
Stomach/GI Problems	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Other, Specify:	☐	☐	☐	
Other, Specify:	☐	☐	☐	

Do you exercise at least once a week? ☐ Yes ☐ No How often?
What kind of exercise?

Why do you exercise?

Describe what you ate yesterday:

Do you have any worries about your eating habits?

Have you ever binged, purged, over exercised or significantly restricted caloric intake for managing weight or body image? ☐ Yes ☐ No If yes, please describe:

What strategies do you use for stress management?

What activities do you enjoy?

Substance used					Consequences of use? Tolerance, withdrawal, legal or	Has it ever been a

current or past…	First Use?	How Much?	How Often?	Last Use?	relationship consequences?	problem?
Caffeine						
Tobacco						
Alcohol						
Drugs Type:						
Medications not prescribed to you? Type:						

ADDICTION/RECOVERY

Have you experienced problems (past or present) with any of the following?
☐Alcohol ☐Drugs ☐Gambling ☐Sex/Love Addiction ☐Food ☐Loved one's Addictions ☐Other: _____
☐None
If you marked "None" Please skip to next section.

Please briefly describe your addiction history:

Do you describe yourself as currently "in recovery"? ☐ Yes ☐ No	How Long?
Use of 12 Step Program? ☐ Yes ☐ No	Another Recovery Program? ☐ Yes ☐ No List:

Please describe nature of your recovery:

SOCIAL/FAMILY HISTORY

How would you describe your family?

Current relationship with siblings?	Current relationship with parents?
Did anyone else live in your home when you were growing up other than parents and siblings? ☐ Yes ☐ No If so whom?	
Are you currently in a relationship? ☐ Yes ☐ No	With whom and for how long?

Please describe current relationship:

Please check any environmental factors present during your childhood/adolescence.

☐Parental divorce/separation	☐Death in the family	☐Parental illness
☐Frequent moves	☐Unemployment of parent(s)	☐Financial stress
☐Family member disability	☐Crime victim	☐Emotional abuse
☐Physical abuse	☐Sexual abuse	☐Violence in home
☐Substance abuse by self/parent	Other:	Other:

Please list any legal history (arrests, convictions, lawsuits, DHS involvement, juvenile justice, guardianship): ☐ None	
Are you currently enrolled in school? ☐ Yes ☐ No If 'no' why not?	
What school do you attend?	What grade are you in?
Is school easy or hard for you? Describe:	
Describe your social life at school:	
What do you do after school?	
Are there any problems going on at school? ☐ Yes ☐ No Describe:	
Do your currently work to earn money? ☐ Yes ☐ No	How many hours a week do you work?
Please describe your ethnic, cultural, and/or religious/spiritual background:	
Please describe any further concerns/issues not addressed elsewhere in this questionnaire:	
Please describe outcomes you would like from this visit/treatment from this provider.	

Office Policy Statement

Confidentiality
Information related to your seeking and receiving services will remain confidential. Information will not be disclosed without your written consent. There are a few exceptions:

- When there is reason to believe you may be in danger of harming either yourself or another person.
- When there is reasonable cause to believe abuse or neglect of a child, elder, or someone with disabilities has occurred.
- When a court order is received.
- For insurance billing purposes.
- When an emergency situation requires sharing of information.
- Other situations required by law.

Confidentiality and Treatment of Children and Adolescents
Those individuals under the age of 14 and who are not emancipated are required by law to have a parent/guardian consent for treatment. Treatment records may be reviewed by the parent/guardian. Willamette Health & Wellness (WHW) operates under the belief that privacy of patients is of utmost importance and will be maintained except in those instances listed above and for any necessary communication with parent/guardian for treatment planning. Families play a vital role in the recovery process and as such parent/guardian participation in treatment of minors is very important and in most circumstances is required for effective treatment. Oregon law allows clients 14 years and older to consent to their own mental health treatment by a nurse practitioner but requires the nurse practitioner to involve the parents prior to the ending of treatment except in rare instances.

Children in the Waiting Room
There may be times when you wish to leave a minor child in the waiting room while you are in session with one of our clinicians. Please note that we are unable to provide supervision for children who are unattended in the waiting room. Administrative staff are happy to respond to questions or needs of anyone visiting our offices but they are not able to provide the supervision necessary for a child who requires this. If your child requires supervision you are welcome to bring someone along to attend them. If you have any concerns please speak to your clinician.

Client Participation/Rights
Treatment will only be effective if the client is engaged and actively involved; this includes family members of children and adolescents seeking treatment. It is important to ask questions about treatment if you are unclear about any aspect of treatment goals or plans. This office is compliant with federal privacy laws and you will be provided with a document outlining your rights under these laws.

Scheduling Appointments
Sessions in this clinic are arranged by appointment only. You may call reception to schedule during business hours to schedule. Appointment times vary in length related to individual needs, clinician recommendation, prearranged treatment plan, and as other treatment factors dictate. An initial evaluation will determine if WHW clinicians are appropriate for your treatment needs. Once this has been established a treatment plan will be developed and will guide follow-up appointments.

Late arrival/Cancellation/Missed Appointments
Appointments are the responsibility of the patient. If an appointment is missed with less than 24 hours notification (telephone message may suffice) a fee of $75 will be charged. If you miss your appointment without a call at least 24 notice, you will be charged $125. We allow one "no show"/"late cancellation" without charge. ***Fees for missed or late cancelled appointments are not reimbursable by insurance companies***. If cancelling appointments or no shows become a regular occurrence you may be notified of risk for discontinued treatment.
If you are late, you may lose that portion of time from your session. If you arrive more than 25% into your allotted time period you may have to reschedule and if so will be charged for a late cancellation fee. If your clinicians is late we will make up the missed time.

Telephone Calls and Emergency/Urgent Services

Your provider can be reached during their scheduled business hours. Generally your non-urgent calls will be returned within two business days. Unless otherwise stated on outgoing voicemail message, we check voicemail at least once per day, more often during business hours and attempt to return all calls within 24 hours of receipt of voicemail. We do not carry 24 hour pagers. During weekend hours and when out of town, you will be directed to covering provider(s) who will be assisting with **URGENT** matters only.

In the case of emergency, call 911 or go to the nearest emergency department. In the event of a crisis in which you need assistance before I am able to return you call you may also contact:

- Multnomah County Crisis Line 503-988-4888
- Clackamas County Crisis Line 503-655-8585
- Clark County Crisis Line 503-696-9560
- Washington County Crisis Line: 503-291-9111
- Marion County Crisis Line: 503-585-4949
- Poison Control 503-494-8968 or 800-452-7165
- Alcohol and Drug Help Line 503-244-1312 or 1-800-923-HELP
- Portland Women's Crisis Line (Domestic Violence): 503-235-5533
- Rape Crisis Center: 503-640-5311
- Cascadia Urgent Walk-in Clinic at 2415 SE 43rd Ave 7am-10:30pm
- Additional crisis assistance may be found at: http://www.co.multnomah.or.us/dchs/dv/dvman_crisistb.shtml

If you are hospitalized, please attempt to call your provider within 12 hours or have the hospital call so we can coordinate your care.

Email Communication

We generally do not use email as a form of clinical communication. Treatment assessment and interventions are provided in person and under certain circumstances by phone. There are some situations in which you and/or your provider may decide email for communication. Please note that email is not a secure form of communication according to HIPAA. Though you may send email to Willamette Health & Wellness at your own risk, we will only be able to reply or initiate clinically appropriate emails if you provide written consent. **Email is not intended for urgent communications.**

Medication Management

All medication has potential to cause side effects as well as interact with other prescription/over-the-counter medications or herbal remedies. However, there is no way of predicting all the potential effects a medication may have on a specific individual. Please be advised that medications used in psychiatry are often prescribed "off-label." This means that such medication may be used to treat/manage symptoms other than those for which it was originally approved by the FDA. This will be discussed during treatment planning. Potential risks, benefits and alternatives will be discussed prior to setting a treatment plan. It is important to update all providers about changes in your medications including prescription, herbal and over-the- counter medications.

Prescription Refills

Prescription refills will be available at your regularly scheduled appointments. Please ensure that you attend appointments to receive them. A prescription refill is not an emergency and requests by phone should be infrequent. Please ***allow one week for refill.***

Fee Schedule

Charges are based on length, complexity, and type of service provided as well as licensure of your provider. You may find the fee schedule for your provider on our website.

Payment

As a courtesy we bill all insurances. Payment in full (or copay/coinsurance) is due at time of service. We accept checks, cash and major credit cards. Payment of any outstanding balance must be made within 60 days or by other arrangement with Willamette Health & Wellness. Outstanding balances older than 90 days may be subject to a collections agency. Failure to make payments may result in discontinuation of services and/or may be turned over to an outside collection agent.

It is advisable to call your insurance carrier to find out details of your insurance benefits, including pre-authorization if needed. Most plans limit the services for which they will pay. If you request or agree to a service for which your insurance company or its agent deems patient responsibility, then you assume responsibility for paying the entire balance. Insurance companies often request treatment information which would require release of confidential treatment information before payment is made.

Treatment/Length of Treatment

We approach psychiatric/mental health care as a collaborative process. We work with you and, if you desire, you're other providers to create a plan for treatment and recovery. If you are ever unclear about the goals you establish with your provider or about any other aspects of your treatment please ask your provider. Individuals in therapy often are seen weekly or bi-weekly. Medication appointments begin with appointments weekly and/or semi-monthly and after stabilization will decrease in frequency to monthly or every other month or as mutually agreed with your provider. Length of time recommended for use of medication is based on an individual's symptoms and history of symptoms, response to medication and the individual's desire to continue medication. We strongly suggest individuals who are receiving medication be in therapy as well either by your prescribing provider or another therapist. Discontinuation of treatment may occur when goals have been met, by mutual agreement that another provider may be of better assistance, or when deemed necessary by your provider. Generally we will discuss ending treatment with you well in advance.

Termination of Treatment

Please let your provider know if you are considering discontinuing treatment. Should you not schedule an appointment for a period of 45 days and make no arrangement with your provider in writing, you may no longer be considered in active treatment. If you "no show" or "late cancel" for two consecutive appointments, "no show"/"late cancel" for one appointment without rescheduling within thirty days, or you are otherwise not engaged in treatment, you will be considered to have terminated treatment. When treatment is terminated for any reason and you wish to re-engage treatment with a provider at Willamette Health &Wellness, we will discuss with you options at that time.

Court Testimony

Please be aware and understand that WHW and our clinicians do not wish to be party to any legal proceedings against current or former patients, or their parents. By entering into treatment with us you are agreeing to not involve us in legal/court proceedings or attempt to obtain records for legal/court proceedings when marital or family therapy has been unsuccessful at resolving disputes. Having this expectation reduces the chance that treatment will be misused for legal objectives. If you are involved in, or anticipate being involved in legal or court proceedings, please notify us as soon as possible. It is important for us to understand how, if at all, your involvement in these proceedings might affect our work together. Also, entering into treatment for therapy is not the same as a forensic or custody evaluation. In the event that you need such an evaluation, we would be willing to assist you in finding a provider that offers this service.

In the event that we are subpoenaed, we will make every attempt to protect your confidentiality, but as outlined in the Office Policy Statement, be advised that there may be limitations. Please note that we will charge for our testimony, including travel time, wait time, copies of records, and preparation/consultation time. ***We will charge current legal rate as well as expenses incurred in copying and sending records. You will be responsible for these fees as insurance companies will not pay for this.***

Grievance Procedures

If you have a complaint or concern about your treatment, we encourage you to discuss this with your provider so s/he can address your concerns. Willamette Health & Wellness also has a grievance procedure that you should feel free to use. Grievance forms are available upon request. In the event this is not satisfactory you may also speak to your insurance company or contact the Board of your provider.

HIPAA Privacy Notice

Notice of Privacy Practices

Effective Date: September, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

What is this Notice? Who will follow this Notice and Why is it Important? As of April of 2003, a new federal law ("HIPAA") went into effect. This law requires that health care practitioners create a notice of privacy practices for you to read. This notice tells you how Willamette Health & Wellness, LLC will protect your medical information, how this information may be used or disclosed, and describes your rights. If you have any questions about this notice, please contact the Human Resources Coordinator directly at Willamette Health & Wellness, LLC.

Understanding Your Health Information During each appointment, we record clinical information and store it in your chart. Typically, this record includes a description of your symptoms, your recent stressors, your medical problems, a mental status exam, any relevant lab test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your medical or health record, serves as a basis for planning your care and treatment. Typically we may use your health information and share it in order to:

- *Treat you and communicate with other professionals who are treating you.*

For example: Your primary care physician or your psychotherapist might call us to discuss your treatment, and in that situation we would disclose information about your diagnosis, your medications, and so on.

- *Run our practice, improve your care, and contact you when necessary.*

For example: Occasionally, we dictate notes from visits, usually for letters to other clinicians. In that case, your health information will be disclosed to the transcriptionist.

- *Bill and get payment from health plans or other entities.*

For example: In order to get paid for our services, we have our billing office send a bill to you or your insurance company. The information on the bill may include information that identifies you, as well as your diagnosis, and type of treatment. In other cases, we fill out authorization forms so your insurance company will pay for extra visits, and this includes some information about you, including your diagnosis. We use an electronic health record which may also include information that identifies you including specific health information.

We may be allowed or required to use your information in other ways- usually ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumer/index.html. These additional uses and disclosures may include:

- Sharing health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety.
- Using or sharing your information for health research.
- Sharing information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Sharing information about you with organ procurement organizations.
- Sharing information with a coroner, medical examiner, or funeral director when an individual dies.
- Using or sharing health information about you for worker's compensation claims, for law enforcement purposes or with law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.
- Sharing information about you in response to a court or administrative order in response to a subpoena.

Your Health Information Rights You have the following rights related to your medical record:

- *Obtain a copy of this notice*.

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

- *Authorization to use your health information*.

Before I use or disclose your health information, other than as described in this notice, I will obtain your written authorization, which you may revoke at any time to stop future use or disclosure.

- *Access to your health information*.

You may ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge reasonable, cost-based fee.

- *Change your health information*.

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

- *Request confidential communications*.

You may request that when we communicate with you, we do so in a specific way (e.g. at a certain mail address or phone number). We will make every reasonable effort to agree to your request.

- *Accounting of disclosures*.

You may request a list of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

- *Choose someone to act for you*

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

- *Ask us to limit what we use or share*.

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

- *File a complaint if you feel your rights were violated*.

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the US Department of Health and Human Services for Civil Rights by sending a letter to 200 Independence Ave, SW, Washington, DC 20201, calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Our Responsibilities

- We are required by law to protect the privacy of your health information, to provide this notice about our privacy practices, and to abide by the terms of this notice.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We reserve the right to change our policies and procedures for protecting health information. When we make a significant change in how we use or disclose your health information, we will also change this notice.
- Except for the purposes related to your treatment, to collect payment for our services, to perform necessary business functions, or when otherwise permitted or required by law and as described above, we will not use or disclose your health information without your authorization. You have the right to revoke your authorization at any time.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Will We Disclose Your Health Information to Family and Friends? While the new law allows such disclosures without your specific consent (as long as it contributes to your treatment), our office policy is that we will generally not share your clinical information with your family without a signed authorization from you. The BIG EXCEPTION to this is if I believe you pose an immediate danger to yourself or someone else—in that case, we will do whatever is necessary, even if that means breaching confidentiality.

For More Information or to Report a Problem. If you have questions, would like additional information, or want to request an updated copy of this notice, you may contact us at Willamette Health & Wellness at any time. If you feel your privacy rights have been violated in any way, please let us know and we will take appropriate action.

You may also send a written complaint to:
Department of Health & Human Services, Office of Civil Rights,
Hubert H. Humphrey Building 200 Independence Avenue
S.W. Room 509 HHH Building
Washington, D.C. 20201

Authorizations and Informed Consent

Print Patient name: _____ **Patient date of birth**: _____

Acknowledgement of Office Policies

___Initial___ I have received, read, understand, and agree to the office policies as outlined in the Office Policy Statement for Willamette Health & Wellness, LLC (WHW).

Consent for Treatment

___Initial___I freely and voluntarily consent to treatment provided by Willamette Health & Wellness, LLC. I understand that I have the right to terminate my participation at any time.

HIPAA Receipt and Release

___Initial___ I have been given opportunity to review and keep a copy of our HIPAA Privacy Notice. I have received, read, understood and had the opportunity to ask us any questions about this policy.

Authorization for Release of Information and Assignment of Insurance Benefits

_____Initial_____ Willamette Health & Wellness has my permission to communicate with my insurance company and to provide information necessary for the purposes of obtaining authorization for services and benefit information. Willamette Health & Wellness has my permission to bill my insurance company and to provide necessary information for the purposes of obtaining payment.

Patient Responsibility

___Initial___ I understand that there is a fee for professional services rendered. As a courtesy, Willamette Health &Wellness will bill my insurance company. I have been informed that I will be billed any amount my insurance company deems "**Patient Responsibility**." I understand that I am ultimately responsible for any fees incurred at Willamette Health & Wellness. I may receive an additional bill after my visit if the billing department discovers a billing discrepancy. I acknowledge any unpaid or overdue balances may be subject to collections. I acknowledge that any money credited as overpayment due to me will be refunded after completion of treatment upon request.

Missed Appointment/Late cancel Fees

___Initial___ If an appointment is missed with less than 24 hours notification (telephone message may suffice) a fee of $75 will be charged. If you miss your appointment without a call at least 24 notice, you will be charged $125.

Billing and Insurance

For billing purposes, I authorize the below the person(s) to discuss insurance and/or make payments.

_____Initial_____ Print Name: _____ Relationship: _____

_____Initial_____ Print Name: _____ Relationship: _____

****

My signature below verifies my agreement to all initialed agreements above.

Signature of patient: _____ Date: _____

Signature of guardian: _____ Date: _____
(If applicable)

Print Guardian Name: _____ Relationship to patient: _____