PATIENT INFORMATION AND MEDICAL HISTORY FORM

PATIENT DEMOGRAPHICS

Preferred Called Name:____________________________________ Age:____________________

Last Name:________________________________ First Name:________________________________

Date of Birth:__________________________ Social Security Number:________________________

CONTACT

Home:____________________________ Work:_______________________ Cell:___________________

May we leave a detailed message? □ Yes □ No IF YES, please circle the preferred number.

Email:____

May we email you for appointment reminder, confidential results, promos, etc? □ Yes □ No

Preferred appointment reminder: Email Text Message Phone[h] Phone[w] Phone[c]

ADDRESS

Address:____

City:_______________________ State:________________________ Zip:______________________

EMPLOYMENT

Employer:__________________________ Occupation:__________________________________

EMERGENCY CONTACT

Last Name:________________________________ First Name:_______________________________

Phone number:____________________________ Relationship to Patient:_____________________

FINANCIALLY RESPONSIBLE PARTY (Complete if NOT self/patient is a MINOR/NOT the main policy holder)

Last Name:_________________________________ First Name:_________________________________

Relationship to patient:______________________ Date of Birth____________ SSN:_______________

Address:___________________________________ Phone:___________________________________

PRIMARY PHYSICIAN

Physician Name:_____________________________ Physician Phone:__________________________

Physician Address:____

PREFERRED PHARMACY

Pharmacy Name:_____________________________ Address:______________________________

Phone:______________________________________ Fax:___________________________________

Patient Name:
DOB:
Medical/TDCJ #:
Provider Name:
Telemedicine site:

Informed Consent to Telemedicine/Telepharmacy Consultation

I have been asked by my healthcare provider to take part in a telemedicine/telepharmacy consultation with Texas Tech University Health Sciences Center (TTUHSC) and its physicians, associates, technical assistants, pharmacists, affiliated hospitals and others deemed necessary to assist in my medical care through a telemedicine consultation.

I understand the following:

1. The purpose is to assess and treat my medical condition.
2. The telemedicine/telepharmacy consult is done through a two-way video link-up whereby the physician or other health provider at TTUHSC can see my image on the screen and hear my voice. However, unlike a traditional medical consult, the physician or other health provider does not have the use of the other senses such as touch or smell; and it may not be equal to a face-to-face visit.
3. Since the telemedicine consultants practice in a different location and do not have the opportunity to meet with me face-to-face, they must rely on information provided by me or my onsite healthcare providers. The TTUHSC and affiliated telemedicine/telepharmacy consultants can not be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others.
4. I can ask questions and seek clarification of the procedures and telemedicine technology.
5. I can ask that the telemedicine exam and/or videoconference be stopped at any time.
6. I know there are potential risks with the use of this new technology. These include but are not limited to:
    - Interruption of the audio/video link.
    - Disconnection of the audio/video link
    - A picture that is not clear enough to meet the needs of the consultation
    - Electronic tampering.

   If any of these risks occur, the procedure might need to be stopped.
7. The consultation may be viewed by medical and non-medical persons for evaluation, informational, research, educational, quality, or technical purposes.
8. I understand the examination may be videotaped for internal quality review or as might be required by my health coverage plan, however the video images will only be used for those purposes unless further authorized below.
9. I will not receive any royalties or other compensation for taking part in this telemedicine/telepharmacy consult or associated with any use by TTUHSC.
10. I understand I can make a complaint of my provider to the Texas Medical Board by going online at http://www.tmb.state.tx.us/page/place-a-complaint or calling the Complaint Hotline at 800-201-9353.

I, the undersigned patient, do hereby understand and state that I agree to the above consents that I have initialed as “agree” and I do not agree to any that I have initialed as “decline.”

I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand and agree to its contents. I volunteer to participate in the telemedicine examination. I authorize TTUHSC and the doctors, nurses, and other providers involved to perform procedures that may be necessary for my current medical condition.

Date: ______________________________ **Time:**_____________________ **am/pm**

Signature:______________________________ **Printed Name:**____________________________

Witness: ______________________________ **Interpreter (if applicable):**____________________

Texas Tech University Health Sciences Center **Ambulatory Clinics** **Consent to Treatment/Health Care Agreement**	Patient Label (Name, DOB, MRN)

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by Texas Tech University Health Sciences Center physicians, employees and such associates, assistants, and other health care providers (otherwise referred to as "TTUHSC"), as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment, identification and payment purposes only. I understand that TTUHSC is a teaching institution. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I understand that this Consent to Treatment/Health Care Agreement will be valid and remain in effect as long as I attend or receive services from the TTUHSC Ambulatory Clinics, unless revoked by me in writing with such written notice provided to each clinic I attend or from which I receive services.

RELEASE OF MEDICAL INFORMATION: I understand that my prescriptions and prescription history will be sent, received and shared electronically with other healthcare providers and pharmacies. In addition, my medical records are available to other healthcare providers for treatment purposes through Health Information Exchanges (HIE). An HIE is an electronic system that stores your health information from multiple sources, not just TTUHSC, and may contain mental health and substance abuse information. Providers will attempt to exclude certain mental health and substance abuse records, but some portions of this information may be included. I may opt out of the HIE by completing an Opt-Out form. If I later change my mind, I may opt back in the same way.

I acknowledge that the "Notice of Privacy Practices" provides more information about how TTUHSC and its workforce may use and/or disclose protected health information (PHI). I understand that my PHI includes some but not all of the following like diagnosis, test results, prescriptions, medical history, treatment, my progress or any other such related information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs, or communicable diseases such as Human Immunodeficiency Virus (“HIV”) and Acquired Immune Deficiency Syndrome (“AIDS”). I understand my PHI will only be used or released for treatment, payment or healthcare operations, and as otherwise allowed by law. I understand TTUHSC cannot be responsible for use or re-disclosure of information by third parties.

NOTICE OF PRIVACY PRACTICES:
I have received or reviewed a copy of TTUHSC’s Notice of Privacy Practices. _________ (Patient’s Initials)

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign to TTUHSC physicians and providers and/or the TTUHSC Medical Practice Income Plan my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to TTUHSC physicians and/or Medical Practice Income Plan. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct. **I agree to pay all charges for medical and health care services not covered by, or which exceed, the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer, and agree to make payment as requested by TTUHSC.**

USE OF CELL PHONE OR EMAIL: TTUHSC, its affiliates and agents may use an automated telephone dialing system, texting, and email to contact the cellular telephone number(s) or email addresses that I provide to TTUHSC for appointment and payment purposes.

ADVANCE DIRECTIVE:
Do you have a current, signed Advance Directive? ____ YES ____ NO
Has a signed copy been provided to TTUHSC? ____ YES ____ NO

By signing below, I agree I have read this form or it has been read to me and I understand what it is saying and agree to the terms.

________________	____________________________	___________________________________
Date	**Print Name**	**Signature Patient/ legally authorized person**

______________________	______________________
Witness/Translator	**Relationship to Patient**

Consent to Treatment/Health Care Agreement
TT10

Texas Tech University Health Sciences Center **Confidential Communication Request**	Patient Name: ______________ MRN: ______________ DOB: ______________

TTUHSC values the privacy of its patients and is committed to operating our practice in a manner that promotes patient confidentiality while providing high quality patient care. TTUHSC will accommodate reasonable requests.

If you need copies of medical records, you will need to complete a different authorization form. Please ask a staff member for the required form.

☐ Permission to give verbal protected health information (including appointment information) and leave messages with the following person(s): Example: family members, friends, personal caregivers, etc. You do not need to list any medical providers who are involved in your care. The patient and individuals listed below must provide at least one of the following: patient's address, patient's date of birth, last four digits of the patient's Social Security number.

Name: ______________ Relationship: __________ Phone #: __________

Name: ______________ Relationship: __________ Phone #: __________

Name: ______________ Relationship: __________ Phone #: __________

Please note that TTUHSC cannot leave specific test results or details of treatment plan on answering machines or voice mail due to our concern for your privacy.

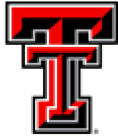
Please complete the following questions for additional level of security which staff may ask if they have concerns on releasing your information. **Please provide at least one answer.**

1. What was your mother's maiden name? ______________________
2. What town were you born in? ______________________
3. What is your grandmother's name? ______________________
4. What is the name of your first pet? ______________________

______________	______________	______________
Date	**Print Your Name and Relationship to Patient (Person signing consent form)**	**Signature (Patient or Other Legally Authorized Person)**

____

Relationship to Patient

 Texas Tech University

Health Sciences Center

School of Medicine

This questionnaire helps us gather information about your child and family that will be helpful in determining the type of treatment which would most likely help the problems your child is expecting. Please fill out all of the questions completely as possible.

I. Identifying Information

Child's Name: ____

Last First Middle

Address: ____

Street City State Zip

Date of Birth ____/____/____ Current age ____ **Ethnicity**: White Hispanic Afr. Amer. Asian Other

Grade: ______ School _________________________ District: _______________________

Legal Guardian Bringing Child for Treatment ___________________Relationship to child ________

II. Parents (if parents are separated, please circle parent child lives with most of the time)

Mother: _______________________Hm Phone:________________Wrk Phone:______________

Father: _______________________ Hm Phone: _______________ Wrk Phone:_____________

III. Marital History

	Date of marriage	Date of Divorce/Widowed (If applicable)	Name of Step-Parent
Child's Bio/Adoptive Parent	_____________	_________________	_____________
Mother's 2nd Marriage	_____________	_________________	_____________
Father's 2nd Marriage	_____________	_________________	_____________
Mother's 3rd Marriage	_____________	_________________	_____________
Father's 3rd Marriage	_____________	_________________	_____________

If parents are separated, does the non-custodial parent want to be involved in the treatment of the child? ( ) Y ( ) N

If YES: do you think the non-custodial parent will object to medication or counseling for your child? ( ) Y ( ) N

Mom/step-mother's educational level: 1. Less than 7th grade 2. 8-9th grade 3. 10-11th grade 4. High school graduate 5. Partial college (at least 1 yr.) 6. Standard college degree (i.e. 4 yrs.) 7. Graduate degree beyond college Current occupation: _______________________	Father/step-father's educational level: 1. Less than 7th grade 2. 8-9th grade 3. 10-11th grade 4. High school graduate 5. Partial college (at least 1 yr.) 6. Standard college degree (i.e. 4 yrs.) 7. Graduate degree beyond college Current occupation: _______________________

IV. Brothers and sisters or other family members in child's main residence

1. ____ Age (   )
2. ____ Age (   )
3. ____ Age (   )
4. ____ Age (   )
5. ____ Age (   )
6. ____ Age (   )
7. ____ Age (   )

V. Child's problems

Please briefly describe your child's problems: ____

____

____

____

____

____

____

____

____

____

____

____

VI. Child's Health History

A. Mental Health Treatment

Please list any medications your child is on now or has been on in the past for behavioral/emotional problems:

Medicine	Doctor	Dates taken	Results
			Good Fair Poor
			Good Fair Poor
			Good Fair Poor
			Good Fair Poor

Has your child been in therapy or counseling before? Yes No

Therapist/clinic	When	No. of Times seen	Results
			Good Fair Poor
			Good Fair Poor
			Good Fair Poor

Has your child been in a psychiatric (mental) hospital before? Yes No

Hospital	When	Doctor	Results
			Good Fair Poor
			Good Fair Poor
			Good Fair Poor

B. Medical History

Please list any serious illness, operations, or hospitalizations:

Child's age When ill	Type of illness/injury	Treatment

C. **Did you have any difficulties during your pregnancy or during child birth? If yes, please describe:**
____

____

____

VII. Development

At what age did your child:

Hold his/her heap up _____________ Smile ________________ Sit up_____________

Take first steps __________________ Walk ________________ Run ______________

Babble, coo ______________________ Say first words ________ Use sentences _____

Toilet trained ___________________ Was toilet training easy/hard? ________________

Did he/she suffer from colic? If yes, please describe: __________________________________

____

As an infant or toddler did your child have trouble attaching or bonding to either parent? If yes, please describe: ____

____

Did he/she have or had any speech delays or problems? ________________________________

____

____

Does he/she have problems with poor motor coordination (being clumsy?) _________________
If yes, please describe: ____

____

Does your child have a main best friend? Yes No

Does your child have a steady group of friends? Yes No

Does your child have trouble making friends? Yes No

Does he/she have trouble keeping friends? Yes No

Does he/she have friends who get him/her in trouble? Yes No

Is he/she a leader or a follower? ____________________________

Do neighbors tell their child not to interact with your child? Yes No

Do other children think your child is "weird" or "odd"? Yes No

Do other children think your child is mean? Yes No

Does he/she play mostly with younger children? Yes No

Do teachers/day care workers say your child doesn't get along with other children? Yes No

VIII. Child's Schooling

Please list the schools your child has attended since Kindergarten:

Grade School	Teacher reported behavior or learning problems?	In Special Education?
K ________________________	Yes No	Yes No
1st ________________________	Yes No	Yes No
2nd ______________________	Yes No	Yes No
3rd ______________________	Yes No	Yes No
4th ________________________	Yes No	Yes No
5th ______________________	Yes No	Yes No
6th ________________________	Yes No	Yes No
7th ________________________	Yes No	Yes No
8th ________________________	Yes No	Yes No
9th ________________________	Yes No	Yes No
10th ______________________	Yes No	Yes No
11th ______________________	Yes No	Yes No
12th ______________________	Yes No	Yes No

IX. Child's Activities

Bedtime on School Days: ___________ Weekends/holidays: _______ Sleeps by self? ___________

Typical bedtime behavior: Goes to bed easily Argues/resists Scared/needs reassurance

Wets bed? Yes No Nightmares? Yes No Sleepwalking? Yes No Loud snoring? Yes No

Wake up time school days: _______ Wake up time weekends: ______ Hours sleep/night: _____

Avg. hour's television watched on school nights: ______________ Weekend: ________________

What sports is child involved in? ____

____

____

What other structured activities (scouts, church, etc.) is the child involved in? ______________

____

____

Describe child's computer/internet usage: ____

____

____

Each rating should be based on what is appropriate for the age of your child. Please rate child's behaviors observed in the past 6 months, using these frequency codes:

0= **Never** 1=**Occasionally** 2=**Often** 3= **Very Often**

1.	Does not pay attention to details or makes careless mistakes with (i.e.) homework.	0	1	2	3
2.	Has difficulty sustaining attention to tasks/activities.	0	1	2	3
3.	Does not seem to listen when spoke to directly.	0	1		3
4.	Does not follow through when given directions and fails to finish activities (not due to oppositional behavior or failure to understand).	0	1	2	3
5.	Has difficulty organizing tasks and activities.	0	1	2	3
6.	Avoids, dislikes, or is reluctant to start tasks that require continuous mental effort.	0	1	2	3
7.	Loses things necessary for tasks or activities (toys, assignments, pencils, books).	0	1	2	3
8.	Is easily distracted by noises or other stimuli around him/her.	0	1	2	3
9.	Is forgetful in daily activities.	0	1	2	3
10.	Fidgets with hands or feet or squirms in seat.	0	1	2	3
11.	Leaves seat when remaining seated is expected.	0	1	2	3
12.	Runs or climbs too much when remaining seated is expected.	0	1	2	3
13.	Has difficulty playing quietly.	0	1	2	3
14.	Is "on the go" or acts as if "driven by a motor".	0	1	2	3
15.	Talks too much.	0	1	2	3
16.	Blurts out answers before the questions have been completed/	0	1	2	3
17.	Has difficulty waiting his or her turn.	0	1	2	3
18.	Interrupts/intrudes on others (i.e. butts into conversations or games).	0	1	2	3
19.	Argues with adults.	0	1	2	3
20.	Loses temper.	0	1	2	3
21.	Actively defies/refuses to go along with adults' request or rules.	0	1	2	3
22.	Deliberately annoys people.	0	1	2	3
23.	Blames other for his/her mistakes/misbehaviors.	0	1	2	3
24.	Is touchy or easily annoyed by others.	0	1	2	3
25.	Is angry or resentful.	0	1	2	3
26.	Is spiteful and vindictive (i.e. wants to get even).	0	1	2	3
27.	Bullies, threatens, or intimidates others.	0	1	2	3
28.	Starts physical fights.	0		2	3
29.	Lies to obtain goods or to avoid obligations (i.e. "cons" others).	0	1	2	3
30.	Is truant from school (skips school) without permission.	0	1	2	3

31.	Is physically cruel to people.	0	1	2	3
32.	Has stolen things that have value.	0	1	2	3
33.	Deliberately destroys others' property.	0	1	2	3
34.	Used a weapon that can cause serious harm (bat,knife,brick,gun).	0	1	2	3
35.	Is physically cruel to animals.	0	1	2	3
36.	Has deliberately set fires to cause damage.	0	1	2	3
37.	Has broken into someone else's home, business, or car.	0	1	2	3
38.	Has stayed out at night without permission.	0	1	2	3
39.	Has run away from home.	0	1	2	3
40.	Has forced someone into sexual activity.	0	1	2	3
41.	Is fearful, anxious, or worried.	0	1	2	3
42.	Is afraid to try new things for fear of making mistakes.	0	1	2	3
43.	Feels worthless or inferior.	0	1	2	3
44.	Blames self for problems, feels guilty.	0	1	2	3
45.	Feels lonely, unwanted or unloved: sys that "no one loves" him/her.	0	1	2	3
46.	Is sad, unhappy, or depressed.	0	1	2	3
47.	Is self-conscious or easily embarrassed.	0	1	2	3

Below is a list of statements that describe how people feel. Read each phrase and decide if it is "not true or hardly ever true", or "somewhat true or sometimes true" or "very true or often true" for your child. Then for each sentence, circle the number that corresponds to the response that seems to describe your child for the last 3 months.

		Not true; hardly ever true	Somewhat true: sometimes true	Very true; often true
1.	My child gets really frightened for no reason at all.	0	1	2
2.	My child is afraid to be alone in the house.	0	1	2
3.	People tell me that my child worried too much.	0	1	2
4.	My child is scared to go to school.	0	1	2
5.	My child is shy.	0	1	2

This form is about how your child might have been feeling or acting recently.
For each question, please check how much he or she has felt or acted this way in the past 2 weeks.
If a sentence was true most of the time, circle 2= TRUE. If it was only sometimes true, circle 1= SOMETIMES. If a sentence was not true, circle 0= NOT TRUE.

		NOT TRUE	SOME-TIMES	TRUE
1	He/she felt miserable or unhappy.	0	1	2
2	He/she didn't enjoy anything at all.	0	1	2
3	He/she was less hungry than usual.	0	1	2
4	He/she ate more than usual.	0	1	2
5	He/she felt so tired he/she sat around and did nothing.	0	1	2
6	He/she was moving and walking more slowly than usual.	0	1	2
7	He/she was very restless.	0	1	2
8	He/she felt he/she was no good no more.	0	1	2
9	He/she blamed himself/her for things that weren't his/her fault.	0	1	2
10	It was hard for him/her to make up his/her mind.	0	1	2
11	He/she felt grumpy and cross with you.	0	1	2
12	He/she felt like talking less than usual.	0	1	2
13	He/she was talking more slowly than usual.	0	1	2
14	He/she cried a lot.	0	1	2
15	He/she thought there was nothing good for him/her in the future.	0	1	2
17	He/she thought life wasn't worth living.	0	1	2
18	He/she thought about death or lying.	0	1	2
19	He/she thought his/her family would be better off without him/her.	0	1	2
20	He/she thought about killing himself/her.	0	1	2
21	He/she found it hard to think properly or concentrate.	0	1	2
22	He/she thought bad things would happen to him/her.	0	1	2
23	He/she hated himself/her.	0	1	2
24	He/she felt he/she was a bad person.	0	1	2
25	He/she thought he/she looked ugly.	0	1	2
26	He/she worried about aches and pains.	0	1	2
27	He/she felt lonely.	0	1	2
28	He/she thought nobody really loved him/her.	0	1	2
29	He/she didn't have any fun at school.	0	1	2
30	He/she thought he/she could never be as good as other kids.	0	1	2
31	He/she felt he/she did everything wrong.	0	1	2
32	He/she didn't sleep as well as he/she usually sleeps.	0	1	2
33	He/she slept a lot more than usual.	0	1	2
34	He/she wasn't as happy as usual, even when praised or rewarded him/her.	0	1	2

The following questions concern your child's mood and behavior in the **past month**. Please place a check mark or an 'X' in a box for each item. Please consider it a problem if it is **causing trouble** and is beyond what is normal for your child's age. Otherwise, check 'rare or never' if the behavior is not causing trouble.

	Does your child…	Never rarely	Some times	Often	Very often
1	Have periods of feeling super happy for hours or days at a time, extremely wound up and excited, such as feeling "on top of the world"	0	1	2	3
2	Feel irritable, cranky, or mad for hours or days at a time.	0	1	2	3
3	Think that he/she can be anything or do anything (i.e., leader, best basketball player, rap singer, millionaire, princess) beyond what is usual for that age	0	1	2	3
4	Believe that he/she has unrealistic abilities, or powers that are unusual, and may try to act upon them, which causes trouble	0	1	2	3
5	Need less sleep than usual: yet does not feel tired the next day	0	1	2	3
6	Have periods of too much energy	0	1	2	3
7	Have periods when he/she talks too much or too loud or talks a mile minute	0	1	2	3
8	Have periods of racing thoughts that his/her mind cannot slow down, and it seems that your child's mouth cannot keep up with his/her mid	0	1	2	3
9	Talk so fast that he/she jumps from topic to topic	0	1	2	3
10	Rush around doing things nonstop	0	1	2	3
11	Have trouble staying on track and is easily drawn to what is happening around him/her	0	1	2	3
12	Do may more things than usual, or is unusually productive or highly creative	0	1	2	3
13	Behave in a sexually inappropriate was (i.e., talks dirty, exposing, playing with private parts, masturbating, making sex phone calls, humping on dogs, playing sex games, touches others sexually)	0	1	2	3
14	Go and talk to strangers inappropriately, is more socially outgoing than usual	0	1	2	3
15	Do things that are unusual for him/her that are foolish or risky (i.e., jumping off heights, ordering CDs with your credit cards, giving things away)	0	1	2	3
16	Have rage attacks, intense and prolonged temper tantrums	0	1	2	3
17	Cracks jokes more than usual, laugh loud or act silly in a way that is out of the ordinary	0	1	2	3
18	Experience rapid mood swings	0	1	2	3
19	Have suspicious or strange thoughts	0	1	2	3
20	Hear voices that nobody else can hear	0	1	2	3
21	See things that nobody else can see	0	1	2	3

Traumatic Events

In this form, we ask questions about things that sometimes happen to kids and teenagers. Some of these things may have been upsetting or scary to your child. If the event has never occurred to your child, please mark the box under the word “No”. If the event has occurred but was not upsetting or scary to your child, please mark the box under the word “Yes”. If the event occurred and was scary/upsetting to your child, please mark the box under that choice. Please think carefully about each question. We may talk to you further about your answers. Please mark the appropriate box for each question.

		YES	**NO**	**Yes;was upsetting or scary**
1	Has your child ever been in a really bad accident? i.e. car accident, fall or a fire?			
2	Has your child ever witnessed a really bad accident that he/she was not in?			
3	Has your child ever been in a really bad storm, like a tornado, hurricane, or a blizzard? Or a flood, or earthquake? Or was your child ever been struck by lightning?			
4	Has your child ever known someone who got really hurt or sick or even died?			
5	Has someone ever attacked your child or tried to hurt your child really bad on purpose?			
6	Has someone ever told your child that they were going to hurt him/her really badly, or acted like they were going to hurt him/her badly?			
7	Has someone a lot older tried to rob or steal from your child?..Or mug your child?			
8	Has someone ever kidnapped your child or taken your child away when they weren’t supposed to?			
9	Has your child ever seen people not in your family fighting/attacking each other? Or shooting with a gun? Or stabbing with a knife? Or beating each other up?			
10	Even if they were weren’t physically attacking each other, has your child ever heard people in your family yelling and screaming at each other a lot?			
11	Has someone ever touched your child’s body’s private parts in a way that your child didn’t want or that made your child feel uncomfortable? Or made your child touch their body’s private parts? Or made your child do something sexual that your child didn’t want to do?			
12	Has anyone ever physically hurt or injured your child really badly on purpose?			
13	Has there been some other time when something happened that really made your child feel scared or upset, or that bothers your child a lot now? What happened?			

If you said yes to any of the above events:

Do you worry your child’s current problems are related to the traumatic events? YES NO

Does your child ever seem like he/she is re-living the trauma? YES NO

Does he/she have lots of nightmares about the trauma? YES NO

Does he/she have flashbacks about the trauma? YES NO

Family History

If your family members have history of mental illness, or have mental illness at present, please write the **"X"** sign in the box under the group that it applies to (mother, father, sibling or others). If you are not sure but suspect that they have mental illness, please write a question mark **"?"** in the appropriate box. If family members don't have mental illness, please leave the boxes **empty.**

Disorder:	Mother	Father	Siblings	Others	Comment
1) ADHD					
2) Learning Disability					
3) Mental Retardation					
4) Psychosis/ Schizophrenia					
5)Manic depressive/bipolar disorder					
6) Major depressive disorder					
7) Suicide					
8) Anxiety Disorder					
9) Tics/Tourette syndrome					
10) Alcohol Abuse					
11) Substance Abuse					
12) Inpatient psychiatric hospitalization					
13)Epilepsy/Seizures					
14) Other mental problems:					

________________________________ ____________________ ____________________________

Name of person filling out form **Relationship to child** **Signature** **Date**

Reviewed by clinician: ________________________________ Date: ____/____/______

Treatment Goals Checklist

This information is being collected under the authority of the Health and Social Service Authority in order to provide services. It is protected by the privacy provisions of the Access to information and Protection of Privacy (ATIPP). If you have questions about the collection or use of the information, please contact the manager/supervisor at the program providing the service. (The receptionist can direct you to the manager or supervisor)

Client Name: ________________________________ Date: __________________________

The following is a list of goals that people coming to treatment sometimes have. Please indicate what your present goals are by circling yes and which are not your present goals by circling no.

1. To deal with my problem of alcohol and/or drug use and/or gambling.	Yes	No
2. To learn to manage stress appropriately.	Yes	No
3. To learn to stand up for myself better.	Yes	No
4. To be able to deal with my feelings and express them directly.	Yes	No
5. To improve my relationship with members of my family (spouse, children, parents, etc.).	Yes	No
6. To be able to get along better socially.	Yes	No
7. To improve my ability to find and keep a job.	Yes	No
8. To learn to use my leisure time better.	Yes	No
9. To improve my living arrangements.	Yes	No
10. To deal effectively with my financial problems.	Yes	No
11. To deal effectively with my legal problems.	Yes	No
12. To deal effectively with my medical problems.	Yes	No
13. To manage my emotional/mental health issues appropriately.	Yes	No
14. Other-Please specify ______________________________________	Yes	No

Summary

How many goals have you indicated? ________________________

Of the goals you indicated, which are the most important for you to solve at the moment?

My first most important goal is # ________________________

My second most important goal is # ________________________

My third most important goal is # ________________________