ACHIEVE WHOLE RECOVERY
1115 Elkton Drive, Suite 300 Colorado Springs, CO 80907
Pediatric (14 Years or younger) Intake Forms

Name: ______________________________ Birthdate: ____________________

Address: ____

Email: ____

Insurance Provider: ____

Relationship to the insurance subscriber? ________________________________

Member ID: ______________________ Group #: _________________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand I am financially responsible for any balance. I authorize the release of any information required to process my claims.

Signature: ____________________________ Todays Date: ______________________

Best Phone to Contact you and leave message at: __________________________

Is it OK to leave a message at this number? YES _____ or NO _____

Primary Care Name, Address and Phone Number: _____________________________

Therapist Name, Address and Phone Number: ________________________________

____

Preferred Pharmacist Phone Number and Address: ___________________________

____

In case of an emergency, Name & Phone Number who to call: _________________

____

May I share information with this person(s) about your mental health condition?

YES _____ or NO _____

Please bring all medication bottles including supplements to your first appointment. Also, if you have any lab work from the past 12 months, medical records you would like reviewed, Neuro-Psych Testing results, ADHD evaluations, MRI results, etc. Please bring all of this with you to your intake appointment. Knowing the names and dosages of your current medications are very important.

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CHILD:

1. Child's Name ________________________ Sex _____ Age _____ DOB ____________
2. Natural Child YES ___ NO ___ If adopted, at what age ___ Foster Since ___________
3. Parent's Names (include step-parents, foster parents, inc.)

   ____

   ____

4. Comments about custody and visitation (if applicable):

   ____

   ____

5. Primary reason you are concerned about your child?

   ____

   ____

   ____

SYMPTOM/PROBLEM CHECKLIST

Check any symptoms that are a concern. How long has it been a problem?

a.
- _____ Sleep problems
- _____ Lack of interest in activities
- _____ Unassertive
- _____ Fatigue / low energy
- _____ Concentration problems
- _____ Appetite / weight changes
- _____ Withdrawal
- _____ Morbid thoughts
- _____ Suicidal thoughts or threats
- _____ Suicidal plans / attempts
- _____ Mood swings
- _____ Depression
- _____ Changed level of activity
- _____ Cries easily

b.
- _____ Forgetful / memory problems
- _____ Short attention span
- _____ Aggressive behavior
- _____ Can't sit still
- _____ Not interested in peers
- _____ Picked on/ bullied by peers
- _____ Talks excessively / interrupts
- _____ Easily distracted
- _____ Irritable
- _____ Impulsive
- _____ Difficulty following rules
- _____ Problem completing schoolwork

c.
- _____ Excessive worry / fearfulness
- _____ Anxiety or panic attacks
- _____ Social fears, shyness
- _____ Separation problems
- _____ Bedwetting / soiling
- _____ Headaches / stomachaches
- _____ Odd beliefs / fantasizing
- _____ Nightmares
- _____ Frequent tantrums
- _____ Resistive to change
- _____ School refusal
- _____ Perfectionism
- _____ Odd hand / motor movements
- _____ Hallucinations

d. _____ Lying
_____ Trouble with the law
_____ Running away
_____ Truancy / skipping school
_____ Hurting others sexually
_____ Alcohol / drug use
_____ Argumentative / defiant
_____ Swears
_____ Blames others for mistakes
_____ Stealing
_____ Being destructive
_____ Fire setting
_____ Hurting others / fighting
_____ Acts as if has no fear
_____ Short tempered
_____ Easily annoyed / annoys others
_____ Discipline problem
_____ Angry and resentful

BROTHERS AND SISTERS

First Name - Last Name	Sex	Age	Relationship to child (full, step, half, foster)
1.			
2.			
3			
4			
5			
6			

SCHOOL HISTORY

1. Present School: ______________________________ Grade: ___ Teacher: _____________

2. Has child *ever* repeated any grade? ____

3. Is child in special education services? No _____ Yes _____, what kind? _______________

4. Please describe academic or other problems your child has had in school

____

CHILD'S DEVELOPMENTAL AND MEDICAL HISTORY

1. **Pregnancy**

Mother used during pregnancy: alcohol _____ drugs _____ cigarettes _____

Delivery: Normal _____ Breech _____ Cesarean _____ Transectional _____

Full-tem _____ Premature _____ if premature, number of weeks _____

Birth Weight ___________

Problems at birth: (for example: infant given oxygen, blood transfusion, placed in an Incubator, etc) ____

2. **Developmental History**

- State approximate age when child did the following:

  Walked alone _____ Said first word _____ Used 2-word phrases _____
- Understood and followed simple directions _____
- Reasonably well toilet trained _______
- Did child cry excessively? _____ Rarely cried _____

3. **Health History of Child**

In the first two years, did your child experience: _____ Separation from mother, _____ Out of home care, _____ Disruption in bonding, _____ Depression of mother, ___ Abuse, _____ Neglect, _____ Chronic pain, _____ Chronic Illness, _____ Parental Stress

- Child's Doctor: ____
- Date of last physical exam: _________________________
- Vision problems? Yes _____ No _____ Hearing problems? Yes _____ No _____
- Dental problems? Yes _____ No _____
- Any head injuries or loss of consciousness? Yes _____ No _____
- Child's history of serious illness, injury, handicaps, or hospitalization?

  No _____ Yes _____ describe and give dates ______________________________
- Is your child currently taking any medications? No _____ Yes _____ name medications

  ____
- List any medicines previously used for emotional problems: were they helpful?

  ____
- Allergies to drugs or medicines? No _____ Yes _____ (list) ______________________
- Allergies to any foods? No _____ Yes _____ (list) _____________________________
- Are there any foods that you limit or do not give this child? No _____ Yes _____

  (list) ____
- Allergies to environmental conditions? No _____ Yes _____ (list) _________________
- Does anyone in the household smoke? No _____ Yes _____
- About how many hours does this child watch TV, videos, etc per day _______________
- Are you afraid someone you know may injure/harm this child? No _____ Yes _____

  National Domestic Violence Hotline 1-800-799-7233

- Does this child have a Health Care Directive? No _____ Yes _____

  If yes, please list where (clinic) it is on file ______________________________________

- Any previous psychological or psychiatric treatment? No _____ Yes _____

  Whom/where _____________________ when __________________________

- Any previous testing (school/psychological)? No _____ Yes _____

  Whom/where _____________________ when __________________________

- Do you think your child's use of chemicals is a problem? No _____ Yes _____

  Type: Alcohol _____ Marijuana _____ Other drugs ____________________________

  Comments: ____

FAMILY HISTORY:

Chemical use (now & past): No _____ Yes _____ Which parent ________________________

Type: Alcohol _____ Marijuana _____ Other drugs __________________________________

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):

____

____

Has child witnessed domestic violence? _____ YES, _____ NO, Specify: _________________

____

How is your child disciplined? Please list each method and frequency of use: _______________

____

____

LIFE STRESSORS/TRAUMA HISTORY

1. Has your child been verbally abused? _____ YES, _____ NO, _____ Suspected. Specify

   ____

2. Has your child been physically abused? ____ YES, _____ NO, _____ Suspected. Specify:

   ____

3. Has your child been sexually abused? _____ YES, _____ NO, _____ Suspected. Specify:

   ____

4. Other stressors or traumas? _____ YES, _____ NO, _____ Suspected. Specify:

   ____

Pediatric (14 Years or younger) Intake Forms

What are your child's strengths?

Any additional comments or information that would be helpful to us?

Signature of person completing form / relationship to client:

Date:

Name Relationship

Center for Epidemiological Studies
Depression Scale for Children (CES-DC)

Number ___________

Score ____________

INSTRUCTIONS
Below is a list of the ways you might have felt or acted. Please check how much you have felt this way during the past week.

DURING THE PAST WEEK	Not at All	A Little	Some	A Lot
1. I was bothered by things that usually don't bother me.	___	___	___	___
2. I did not feel like eating, I wasn't very hungry.	___	___	___	___
3. I wasn't able to feel happy, even when my family or friends tried to help me feel better.	___	___	___	___
4. I felt like I was just as good as other kids.	___	___	___	___
5. I felt like I couldn't pay attention to what I was doing.	___	___	___	___
DURING THE PAST WEEK				
6. I felt down and unhappy.	___	___	___	___
7. I felt like I was too tired to do things.	___	___	___	___
8. I felt like something good was going to happen.	___	___	___	___
9. I felt like things I did before didn't work out right.	___	___	___	___
DURING THE PAST WEEK				
11. I didn't sleep as well as I usually sleep.	___	___	___	___
12. I was happy.	___	___	___	___
13. I was more quiet than usual.	___	___	___	___
14. I felt lonely, like I didn't have any friends.	___	___	___	___
15. I felt like kids I know were not friendly or that they didn't want to be with me.	___	___	___	___
DURING THE PAST WEEK				
16. I had a good time.	___	___	___	___
17. I felt like crying.	___	___	___	___
18. I felt sad.	___	___	___	___
19. I felt people didn't like me.	___	___	___	___
20. It was hard to get started doing things.	___	___	___	___

Center for Epidemiological Studies Depression Scale for Children (CES-DC)

The Center for Epidemiological Studies Depression Scale for Children (CES-DC) is a 20-item self-report depression inventory with possible scores ranging from O to 60. Each response to an item is scored as follows:

0 = "Not At All11
1 = "A Little"
2 = "Some"
3 = "A Lot"

However, items 4, 8, 12, and 16 are phrased positively, and thus are scored in the opposite order:

3 = "Not At All"
2 = "A Little"
1 = "Some"
0 = "A Lot"

Higher CF.5-DC scores indicate increasing levels of depression. Weissman et al. (1980), the developers of the CES-DC, have used the cutoff score of 15 as being suggestive of depressive symptoms in children and adolescents. That is, scores over 15 can be indicative of significant levels of depressive symptoms.

Remember that screening for depression can be complex and is only an initial step. Further evaluation is required for children and adolescents identified through a screening process. Further evaluation is also warranted for children or adolescents who exhibit depressive symptoms but who do not screen positive.

See also
Tool for Families: Symptoms of Depression in Adolescents, p. 126.

Tool for Families: Common Signs of Depression in Children and Adolescents, p. 147.

REFERENCES

Weissman MM, Orvaschel H, Padian N. 1980.
Children's symptom and social functioning self-report scales: Comparison of mothers' and children's reports. *Journal of Nervous Mental Disorders* 168(12):736-740.

Faulstich ME, Carey MP, Ruggiero L, et al. 1986.
Assessment of depression in childhood and adolescence: An evaluation of the Center for Epidemiological Studies Depression Scale for Children (CES-DC). *American Journal of Psychiatry* 143(8):1024-1027.

ACHIEVE WHOLE RECOVERY INFORMED CONSENT FORM

ACHIEVE WHOLE RECOVERY 1115 Elkton Drive, Suite 300 Colorado Springs, CO 80907

Patient Last Name: _________________First: _________DOB: _________Date: __________
Fees: All payments for services are due at the time of service.
Cash pay rates are as follows:

- First general psychiatry appointment: $350
- 15 minute follow-up Psychiatry Medication Management: $125
- **Phone calls**: Brief phone calls (usually less than 5 minutes) to cover issues such as scheduling appointments, reactions to new medications, returning my phone call to you, etc., will not be billed. Extended phone calls or multiple phone calls may be billed an average of $300/hour, and this will be discussed with the patient on a case by case basis.
- **Reports, Consultations, and Other Special Documentation**: In the rare circumstance that my services are needed to prepare specific reports or documentation beyond a routine office appointment, the rate will be $300/hour. These services, if needed, will be fully discussed with the patient prior to the service being provided.
- **Cancelled appointments** with less than 24 hour notice and no-shows will be billed to you at the full rate of the scheduled visit. This included the first appointment and you may be asked to provide credit information to hold your first appointment.

Cancellation policy: Appointments must be cancelled with at least a 24 hour notice. Cancellations made less than 24 hours or missed appointments without notice ("no-shows") will be billed at the full rate of the scheduled visit. Late arrivals will be billed at the full rate without extending the scheduled appointment, and another appointment may be required to complete the service.

Past Due Accounts: Payment is due at time of service. Accepted methods of payment include cash, check, credit card, and debit card. There will be a $25 additional charge on all returned checks added to the full service fee plus any bank charges. Failure to make payment will result in late fees and possible suspension or termination of treatment. Accounts receivable more than 90 days will be assessed a $25 billing fee per month starting with the first month. Past due accounts may be referred to collections-and will include the amount owed plus reasonable attorney fees and court costs.

Collaboration of Care with Other Providers: Communication with other care providers, including your family doctor, therapist, or other clinicians is strongly recommended for the best possible treatment outcome. Please provide their contact information and your consent to communicate with them. Only essential and pertinent medical will be shared with your providers in accordance with privacy laws. Please talk to me about any concerns.

Important health information for females - Pregnancy: All medications pose some danger to the fetus or breastfeeding child. If you are pregnant, feel you may be pregnant, decide to become pregnant, or no longer practice regular birth control, you must notify me as soon as possible so that we can discuss this in advance of a pregnancy. Waiting until you are pregnant may unnecessarily expose the fetus to dangerous medication. Sometimes, the risks of not treating mental illness are greater than the risks of the medication, but treatment will still only be with the consent of the patient, and you will be asked to sign a written consent stating that you understand the risks before treatment is given.

Expectation of Treatment Compliance: Repeated cancelled appointments, at least 2 no-shows/cancellations under 24 hours, or not adhering to the treatment plan such as riot taking medication as prescribed or not following through with therapeutic recommendations will disrupt the plan for treatment. If it becomes evident that there is a recurrent pattern of these issues, the first step will be to discuss solutions to see if this is something that can be worked through. If the issues persist after this step, it will be recommended that you seek care with another provider.

Abuse of Prescription Medications: Abuse or misuse of medication prescribed by Achieve Whole Recovery to you will not be tolerated. This not only includes taking more medication than

prescribed or recommended, but also selling your medication to others, obtaining duplicate prescriptions for controlled substances without our consent, using Narcotics while taking your prescribed medication with our knowledge, or buying prescription medication "off the street." At a minimum, if this occurs you will be reque1sted to seek care with another provider, but there may also be risk of legal consequences. Controlled substances/will be monitored the Prescription Drug Monitoring Program.
Photo Copies and Electronic Signatures: A photo copy of any signed form will be considered as an original copy. An electronic signature will be considered the same as a signature by hand.
Doctor's Absences and After-Hours Calls: Our administrative assistant will fist any upcoming vacations or other absences to help you in planning follow-up appointments or medication refills. Phone calls will be returned within 24 hours except when the office is closed. As noted above, brief telephone calls are not charged, however repeated phone calls and extended calls may result in fees. After-hours calls are managed by a calf-service, and messages left by patients forwarded the next business day, and our staff will respond to all messages by phone calf with that business day. If your calf is of an emergent nature ANYTIME, please go to your nearest emergency room or call emergency services (911). **Please do not delay medical care by waiting for our return call - delays in response can be beyond our control.**
Medication and Refills: If you are taking medication, you agree to take medication only as prescribed and not to ingest any alcohol or illicit drugs. Medication refills should be called into your pharmacy at least five days before running out. Refill requests made on weekends or holidays might not be accommodated until the office reopens during the normal business week. You are responsible for monitoring your supply.
Privacy, Confidentiality and Safety: Personal information shared with us during our sessions is confidential and not shared with anyone without a signed release of information, except under specific legal and safety concerns as defined by laws. If there is an indication of child abuse, risk of danger to self, or risk of danger to others, we are legally bound to report the concerns to the appropriate authorities. ·As noted above, communication with your other care providers including your family doctor, therapist, or other clinicians is strongly recommended for the best possible treatment outcome. Please provide their contact information and your consent to communicate with them. Only essential and pertinent medical will be shared with your providers in accordance with privacy laws. Your signed consent is necessary for us to be able to communicate with them.

Consent for Treatment
I consent to and authorize the attending physician, physician's assistant, and/or nurse practitioner to perform healthcare examinations, treatment, and diagnostic testing as deemed medically necessary in their professional judgment.

1. I have read and understand my responsibilities as outlined by the policies of Achieve Whole Recovery's office as outlined on www.achievewhoferecovery.com.
2. I acknowledge receipt of the HIPAA Notice of Privacy Practices.
3. I have read and understand the above information.
4. I agree to the terms of the office payment and cancellation policies

____

Parent/Guardian Signature DATE

ACHIEVE WHOLE RECOVERY
1115 Elkton Drive, Suite 300 Colorado Springs, CO 80907
Office Phone: (719) 373-9703 – FAX (877) 588-3465
Email: admin@achievewhoferecovery.com
Website: www.achievewhoferecovery.com

AUTHORIZATION TO RELEASE AND OBTAIN MEDICAL INFORMATION ON:

________________________ whose date of birth is ________________ for

Name		Title
Street		
City	State	Zip
Phone		Fax

The following information, including drug and alcohol treatment records, both verbal and writing, for dates and services from AS NEEDED FOR COLLABORATION OF CARE.

Information to be released:
___ Discharge Summary ___ Admission Summary ___ Progress Notes
___ Laboratory Results ___ Psychological Testing and/or Report
_X_ Other: AS NEEDED FOR COLLABORATION OF CARE

Purpose for this release: ___ Continuity of Medical Care ___ Claim Information ___ Legal
___Personal Use
_X_ Other: FOR COLLABORATION OF CARE

Revocation: I understand I have the right to revoke this authorization at any time, except to the extent that it has already been acted on.
Expiration: This release will expire one year from the date signed unless I provide notice sooner.
Conditions: I understand that Dr. Snyder may condition my care and treatment on whether I give authorization for the requested information deemed reasonably necessary to provide quality care and treatment.
Redisclosure: Federal Law (42 CFR Part 2) prohibits any further disclosure of this information without written authorization or as otherwise permitted by 42 CFR Part 2.

______________________________________ ____________________
Patient/Parent/Guardian Signature: Date:

______________________________________ ____________________
Staff Signature: Date:

PATIENT NAME: ________________________________ DOB: ________________

APPOINTMENT REMINDER AUTHORIZATION FORM

Please indicate below which way you would like to be reminded:

EMAIL
I authorize Achieve Whole Recovery to send Appointment Reminders electronically via Email to the following email address.
EMAIL ADDRESS (please print clearly): ____________________________________

TEXT MESSAGE
I authorize Achieve Whole Recovery to send Appointment Reminders electronically via text message to my mobile phone. I understand that this service is offered free of charge. However, standard text messaging rates from my mobile carrier may apply. Please activate text message reminders for the patient/mobile phone number:

MOBILE #: _________________________ MOBILE CARRIER: ________________

VOICE MESSAGE
I authorize Achieve Whole Recovery to contact me for Appointment Reminders via voice messaging. If I am unavailable to answer the telephone, I give Achieve Whole Recovery permission to leave a message on my answering machine or with the person answering the telephone.

TELEPHONE #: __________________________

_____ YES or _____ NO Achieve Whole Recovery may contact me at work to reschedule appointments or confirm existing appointments.

WORK TELEPHONE #: __________________________

Patient Signature: ________________________________ Date: ______________OR

Parent/Legal Guardian Signature: _______________________Date: ______________