



CHILD INTAKE PACKET

Welcome to Provident! Thank you for completing the necessary paperwork to begin services. Please complete the attached forms as completely as possible.

You have been scheduled with: _____

Clinician Name & Credentials

Crisis Services

During regular office hours, please call the office where you receive services and ask to speak to your therapist if you are in crisis or need immediate assistance. If available, your therapist will speak with you and assist you through the emergency. Should your therapist be unavailable, another professional in the office will assist you or you will be referred to Provident Life Crisis Services.

Emergencies After Business Hours: Please call **314-446-2874** for Provident Life Crisis Services so our workers can assist you. Services are available 24 hours a day. In the event that the nature of the emergency is such that you require immediate attention, we ask that you go to the emergency room of the hospital nearest you or call 911 for assistance.

Consent to Treatment

- I have chosen for my child to receive psychotherapy services from Provident. Psychotherapy services include, but are not limited to, Individual, Family, and Group Therapies.
- I understand that there are both risks and benefits associated with treatment.
- I understand that psychotherapy may deal with painful or problematic emotions and experiences. Discussing these experiences may be uncomfortable. However, avoiding the feelings prolongs the discomfort that already exists. During therapy, painful emotions may become more intense, which can be a sign that desired changes are about to occur. I agree to discuss any and all noticeable differences with my child's therapist.
- I understand that participation in therapy requires an openness and honesty between the therapist and my child. I understand that confidentiality is essential to children experiencing difficulties. I understand that confidentiality is extended to children in treatment and that only under certain circumstances is confidentiality broken.
- I understand that treatment is a collaborative process and progress depends on willingness to actively participate in the change process. I understand that my participation and support of therapy is related to the benefits my child will receive.
- I understand there is no guarantee that progress will occur.
- I have the right to be informed about issues such as, but not limited to, the following: the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the clinician's qualifications, credentials, and relevant experience; continuation of services if the clinician is unable to continue providing treatment; and other pertinent information.
- I understand that there are fees associated with therapy and that inability to pay these fees may interrupt the course of treatment.
- I understand that I may stop treatment at any time. I will be responsible for payment of services myself or my child has received. I understand that there may be consequences to ending treatment, such as when treatment is court ordered.
- I understand that Provident may terminate treatment if the needs of myself or my child cannot be met by the agency. I understand that agency staff will refer me to an appropriate alternate provider should this occur.
- I understand that I or my child may not be allowed to continue participating in treatment if I or my child: engage in acts of physical violence or verbal abuse; possess a weapon; are under the influence of alcohol or drugs; or engage in illegal behavior on Provident premises.
- I understand that my child's right for informed consent may be waived in the event that my child is at risk of harm to himself/herself or others and professional intervention is necessary.
- I understand that a surrogate decision maker may provide informed consent on my child's behalf in the event that I and/or my child is in the event that a physician, psychiatrist, and one other mental health professional determine that I and/or my child has lost the capacity to make informed decisions. A surrogate decision maker can only consent to specific mental health services permitted by the Mental Health and Developmental Disabilities Code.

After reading pages 1-4, sign the corresponding sections of the Signature Page (pg. 5).



Client Rights and Responsibilities

As a Provident client, you are entitled to the following **rights**:

- To be treated with respect, consideration, and dignity, including consideration of social, psychological, spiritual and cultural needs without discrimination including race, color, religion, sex, age, national origin, disability, veteran status, gender identity, gender expression, sexual orientation (real or perceived), or any other characteristic protected by applicable United States federal or state law.
- To be informed about issues such as, but not limited to, the following: the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the clinician's qualifications, credentials, and relevant experience; continuation of services if the clinician is unable to continue providing treatment; and other pertinent information.
- To be treated by professionals who uphold the highest ethical standards and to receive services in a safe, clean environment.
- To participate in decisions involving your treatment and suggest changes to treatment.
- To involve family members and other significant others in my treatment and decision making.
- To be informed about the limits of privacy and confidentiality, and to approve or refuse the release of your treatment records, except when release is required by law.
- To receive information concerning your diagnosis, treatment, and prognosis; and to accept or refuse treatment after full information is given.
- To know what services are available within Provident and the availability of after-hours and emergency coverage.
- To be referred to other professionals when additional services not available through Provident are needed or resources outside of Provident can more appropriately serve my needs.
- To be informed of any change in therapist/counselor providing my services during treatment.
- To be assisted in obtaining an interpreter in cases of communication barriers (for example, language or hearing impairment)
- To be assisted in obtaining an advocate to represent you when appropriate.
- To have assistance in accessing protective services in instances of abuse or neglect.
- To access a copy of your medical record and request amendments, when appropriate.
- To know the fee for services provided, the policies regarding payment of fees, and to be informed when fees change.
- To discuss dissatisfaction with services provided with your therapist, by filing a grievance, and by participating in the complaint resolution process. Formal grievances are to be submitted in writing to the supervisor at the office at which you receive services or to the Director of Counseling. The Clinical Supervisor or Director of Counseling will speak with the client and investigate on behalf of the grievor, if necessary. A written statement of results will be given to the grievor/client within five business days and will include: date grievance received, summary of grievance, overview of investigation process, timetable for completing investigation and notification of resolutions. You can contact the **Director of Counseling** at 314-371-6500. Furthermore, you can contact **Missouri Department of Mental Health** (800-364-9687 or constituentsvcs@dmh.mo.gov) or **The Joint Commission** (800-994-6610 or complaint@jointcommission.org) to report any concerns or register complaints about Provident.

As a Provident client, you have the following **responsibilities**:

- To provide, to the best of your knowledge, accurate and complete information about present concerns, past treatment, hospitalizations, medications, and other matters relating to both your physical and mental health.
- To follow the treatment plan developed with your therapist and to be responsible for the consequences of refusing treatment or not complying with treatment recommendations.
- To ask questions when you do not understand treatment recommendations or services that are recommended to you or what is expected of you as a client.
- To share your expectations of Provident and to provide feedback on your satisfaction with services received.
- To pay the established fees for services provided.
- To attend your appointments and, when unable to do so, to notify the office at least 24 hours in advance.
- To provide current information regarding any insurances you have as well as any changes in insurance coverage that occur during the course of treatment at Provident.
- To follow Provident's Policies and Procedures
- To be considerate and respectful of Provident clients, staff, and property.

After reading pages 1-4, sign the corresponding sections of the Signature Page (pg. 5).

Subpoena Policy

Provident and its staff do not respond to subpoenas. Our role is to provide counseling and support for our clients and their families. It is not our role to go to court, to be an expert witness, or to make custodial or other legal decisions on behalf of our clients. In the event that a Provident employee is subpoenaed by a judge regarding your treatment, you will be responsible for all fees incurred, including but not limited to: time reviewing and compiling your medical records, time spent writing reports or treatment summaries, travel time to and from court, and time spent waiting in court and on the stand. **The fee for services provided in response to subpoenas is \$150.00 per hour and must be paid out of pocket by the client, client's parent or guardian, or legal counsel.** As always, we are happy to provide any documentation regarding your treatment in writing once you have signed a Release of Information allowing us to do so.



Notice of Privacy Practice

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.

Introduction: Provident has adopted this Privacy Practice Policy to comply with the Health Insurance Portability and Accountability Act (HIPAA, 1996), the Health Information Technology for Economic and Clinical Health Act (HITECH, 2009), the Omnibus Rule (2013), and the Department of Health and Human Services (DHHS) security and privacy regulations, as well as to fulfill our duty to protect the integrity, confidentiality, and availability of confidential medical information as required by law, professional ethics, and accreditation requirements. All personnel of Provident must comply with this policy. Familiarity with this policy and demonstrated competence in the requirements of the policy are an important part of every employee's responsibilities.

Assumptions: This Notice of Privacy Practice Policy is based on the following assumptions:

- Individually identifiable health information or protected health information (PHI) is sensitive and confidential. Such information is protected by law, professional ethics, and health care accreditation requirements.
- HIPAA requires Provident to protect PHI and to ensure that Provident's Business Associates also protect PHI.
- Provident must enter into Business Associate contracts to protect PHI.
- A Business Associate shall have the meaning specified in the HIPAA Privacy Rule, HIPAA Security Rule, the HITECH Act, and the Omnibus Rule.
- Provident can best perform its duties through the adoption and enforcement of a Privacy Practice Policy.
- Provident workforce members and Business Associates are all bound by this policy, including, but not limited to, any individual who is involved with Provident for the following purposes: employees, volunteers, billing, practicum/internship, and other roles and relationships where access to PHI & ePHI is required.

Provident, its Workforce Members, and Business Associates will:

- Collect, use, and disclose individual medical information only as authorized. Provident's workforce members and Business Associates will not use or supply such information for any purpose other than those expressly authorized by law, professional ethics, and accreditation requirements.
- Implement administrative, physical, and technical safeguards to protect PHI from unauthorized access or disclosures.
- Ensure that medical information must be accurate, timely, complete, and ensure that authorized personnel can access this data when needed.
- Not alter or destroy an entry in a record, but rather designate it as an error while leaving the original entry intact and create and maintain a new entry showing the correct data.
- Implement reasonable measures to protect the integrity of all data.
- Recognize that our clients have a right of privacy and respect clients' individual dignity at all times. Privacy will be respected to the extent that is consistent with performing required services and with the efficient administration of our business.
- Act as responsible information stewards and treat all individual PHI (including medical record data and related financial, demographic, and lifestyle information) as sensitive and confidential.
- Use or disclose only the "minimum necessary" health information to accomplish the particular task for which the information is used or disclosed.
- Disclose information only when there is written authorization for uses or disclosures of psychotherapy notes (if psychotherapy notes are maintained), for uses or disclosures for marketing purpose, and for uses and disclosures that involve the sale of Protected Health Information.
- In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.
- Not divulge PHI unless the client (or his/her authorized representative) has properly consented to the release or the release is otherwise authorized by law.
- When releasing PHI, take appropriate steps to prevent unauthorized re-disclosures, such as specifying that the recipient may not further disclose the information without client consent or as authorized by law.
- Implement reasonable measures to protect the confidentiality of medical and other information.
- Recognize that some medical information is particularly sensitive, such as HIV/AIDS information, mental health and developmental disability information, alcohol and drug abuse information, and other information about sexually transmitted or communicable diseases and that disclosure of such information could severely harm clients, such as by causing loss of employment opportunities and insurance coverage, as well as the pain of social stigma.
- Treat particularly sensitive information with additional confidentiality protections as required by law.
- Recognize that the client has a right of access to information contained in the medical record owned by Provident.
- Permit clients to access and copy their PHI in accordance with the requirements of the privacy regulation, including their electronic medical record and hard-copy medical record.
- Provide clients an opportunity to request correction of inaccurate data in their medical records in accordance with the requirements of the privacy regulation.
- Allow clients to restrict disclosures of PHI to a health plan when the individual pays out of pocket in full for services received.
- Document and provide clients an accounting of uses and disclosures other than those for treatment, payment, and health care operations in accordance with the requirements of the privacy regulation. Breaches of confidentiality will be documented via Incident Report forms.
- Verify that uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the client.
- Provident will inform you if a breach occurs that may have compromised the privacy or security of your information.

Enforcement: All employees, volunteers, and Business Associates of Provident must adhere to this policy. Provident will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment, professional discipline, and criminal prosecution, in accordance with Provident sanction policy and personnel rules and regulations.

After reading pages 1-4, sign the corresponding sections of the Signature Page (pg. 5).



Statement of Confidentiality

As a client at Provident, we want you to be informed of your rights and the limits of confidentiality. The confidentiality of personal information shared with your clinician is the cornerstone of a therapeutic relationship. Only in this way can a client feel free to work with a clinician to discuss and explore problems and arrive at solutions. In most circumstances, information shared is considered privileged communication and will not be shared with anyone, unless the client first provides signed written consent to do so.

There are, however, some limitations of confidentiality which require the disclosure of information. These include, but are not limited to, the following:

- When there is a serious threat of physical harm to yourself or another person (e.g., suicide or homicide);
- When mandated by state or federal law (e.g., in cases of known or suspected physical or sexual abuse or neglect of children, the elderly, or developmentally disabled);
- When specifically ordered by a court of law;
- For the purpose of professional supervision. Cases at Provident are reviewed regularly with a Clinical Supervisor to ensure quality of the care you are receiving;
- When collaborating with or consulting with your treatment team, including but not limited to: case managers, clinicians, supervisors, practicum students/interns, and others that are Provident clinical and administrative workforce members involved in your treatment program. These individuals are bound by confidentiality requirements. A Release of Information is required to share information with individuals outside of your treatment team at Provident;
- When services are provided out in the community where confidential space is not available, such as in school settings or community based programs. In such circumstances, it may be possible for confidential information to be overheard or clients to be seen by others present in the setting. Please note that Provident staff are to exercise discretion to limit and prevent confidential client information from being disclosed in these settings.
- Information gathered from questionnaires, assessments, and surveys that are used for the purpose of data collection, outcome measurement, or research. Please note that any identifying information will be removed from data used;
- The use of insurance implies consent by the insured that information regarding diagnosis, treatment plan, and clinical information may be disclosed to your insurance company in order to facilitate insurance claim filing or management of care with your insurance or managed care company.

If it becomes necessary to release information, it will be done in such a way as to protect the confidentiality of clinical information, as much as possible. We want to assure all clients of our commitment to maintain confidentiality and that their case will be handled professionally and with the highest degree of confidentiality possible.

After reading pages 1-4, sign the corresponding sections of the Signature Page (pg. 5).

Client Fee Information

1. Payment is expected at the time services are provided.
2. All prepaid assessment fees are non-refundable.
3. Insurance and income verification must be submitted prior to or at the first appointment.
4. The client seeking services or parent/guardian seeking services for minor children is responsible for all fees not paid by insurance.
5. By providing Provident with your insurance information, you are consenting to allow information regarding diagnosis, treatment plan, and clinical information to be disclosed to your insurance company for the purposes of claim filing and insurance reimbursement.
6. Insurance deductibles must be met in order for insurance to fund services at Provident. Fees charged to you will equal the standard rate required for all services provided until the deductible is met.
7. The fee for service without insurance will be based on our self-pay scale. The fee for service will be determined by the total household income. Proof of income must be provided in order to be assigned a reduced fee for self-pay services.
8. If a client chooses not to use insurance, the standard rate of services is required for all services.
9. Appointments cancelled less than 24 hours in advance or failure to show for an appointment may result in a fee.
10. Past due balances may interfere with the ability to schedule future appointments.
11. Cash, checks, money orders, and credit cards are acceptable forms of payment.
12. If you have any questions concerning your fees, charges, or payments that cannot be answered at the location where your services are provided, please call the Provident Business Office at 314-802-2636.

After reading pages 1-4, sign the corresponding sections of the Signature Page (pg. 5).



Client ID#: _____
Last Name: _____
Date Scanned to EHR: ___/___/___
Scanned by: _____

Administrative Office ● 2650 Olive Street ● Saint Louis, Missouri 63103 ● 314-371-6500

Signature Page

Child's Name: _____ **Birth Date:** _____ **Parent's Name(s):** _____

Contact Information: Provident may contact me and leave a message by:

■ Home Phone _____ - _____ - _____	■ Cell Phone _____ - _____ - _____
■ Text Message _____ - _____ - _____	■ Email _____

In the case of any emergency, please notify:

Name: _____	Relationship: _____
Phone: _____	Address: _____
Work phone: _____	_____

Consent to Treatment

I have received a copy of Consent to Treatment policies, they have been explained to me, and I understand them. I request services from Provident.

Client/Guardian Signature(s): _____	Date: _____
_____	Date: _____
Witness Signature: _____	Date: _____

Client Rights and Responsibilities

I have received a copy of the Client Rights and Responsibilities, they have been explained to me, and I understand them.

Client/Guardian Signature(s): _____	Date: _____
_____	Date: _____
Witness Signature: _____	Date: _____

Notice of Privacy Practice

I have received a copy of the Notice of Privacy Practice, it has been explained to me, and I understand that Provident follows HIPAA privacy laws and will protect the confidentiality of my protected health information

Client/Guardian Signature(s): _____	Date: _____
_____	Date: _____
Witness Signature: _____	Date: _____

Statement of Confidentiality

I hereby acknowledge that I have read and understand the above Statement of Confidentiality, including the extent to which my clinician is permitted to disclose information about my child.

Client/Guardian Signature(s): _____	Date: _____
_____	Date: _____
Witness Signature: _____	Date: _____

Client Fee Information

I have received a copy of the Client Fee Information, it has been explained to me, and I understand the fees associated with services.

Client/Guardian Signature(s): _____	Date: _____
_____	Date: _____
Witness Signature: _____	Date: _____



Client ID#: _____
 Last Name: _____
 Date Scanned to EHR: ___/___/___
 Scanned by: _____

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Fee Determination Form

Client Name: _____ Client DOB: _____
 Parent Name/Name of Insured: _____ Insured DOB: _____
 Home Address: _____ Apt #: _____
 City: _____ State: _____ Zip Code: _____
 Home Phone: _____ Cell/Other Phone #: _____
 Billing Address (if different than Home): _____ Apt #: _____
 City: _____ State: _____ Zip Code: _____

Insurance Information: I have insurance I do not have insurance
 Name of Insurance Company: _____ ID#: _____ Group ID: _____
 Insurance Card Holder Name: _____ Copay: \$ _____ Deductible: \$ _____

Employment Information: I am employed I am not employed

Total # of people living in household (including yourself): _____

Household Income Information: Please provide income information for all members in your household

Gross Household Income		
Family Member	Employer Name	Annual Income (from IRS Form 1040)
Self:		\$ _____
Significant Other (if living together):		\$ _____
Other Family Members in Household:		\$ _____
Child Support/Alimony (annual amount):		\$ _____
If you did not file a Tax Return, please note Annual Gross Income (before taxes):		\$ _____
Total Annual Gross Household Income:		\$ _____
Fee Amount: \$ _____	Fee amount for Self-Pay Services is based on Total Gross Household Income. Household income information is gathered on all clients to better understand the demographic background on all of our clients. Your income will not negatively impact your ability to receive services.	

I understand that all payments and co-payments are due at time of service. An appointment cancellation notice is required 24 hours in advance to avoid a charge being made to me. I authorize release of any medical or other information necessary for my insurance company/funding source to process claims for services received. I authorize that payment from my insurance company, Medicare, or Medicaid be made on my behalf to Provident for any services provided to me by the agency. I also request payment of government benefits to the party who accepts assignment. This consent remains in my file and can be revoked by me at any time upon written request by me to Provident. If my particular insurance carrier or funding source does random site reviews or audits, I understand that representatives review the contents of my file.

My signature indicates I have read and understand all of the above.

Client/Guardian Signature(s): _____ Date: _____
 _____ Date: _____
 Witness Signature: _____ Date: _____

Please attach copies of:

1. **Insurance, Medicare, and Medicaid Cards** (front & back)
2. **IRS 1040 Tax Return Form or 2 most recent Paycheck Stubs if paying out of pocket for services**
3. **Benefit Statement** (for Unemployment or Social Security Disability) **if paying out of pocket for services**



Client ID#: _____
Last Name: _____
Date Scanned to EHR: ___/___/___
Scanned by: _____

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Guardianship Information Form

Please provide information regarding who is allowed to make medical decisions on behalf of your child.

Child Name: _____ Birth Date: _____ Client ID#: _____

Name(s) of Parent(s) Accompanying Child to Treatment: _____

1. **Are you the child's sole legal guardian?** Yes No
 If **Yes**, skip questions 2-6
 If **No**, please provide contact information for child's other legal guardian and respond to items 2-6.

2. **Contact Information for other parent not accompanying child to treatment:**

Parent Name: _____

Address: _____ Same as Child's Address

Phone: _____

3. **Are you and your child's other parent no longer together, separated, and/or divorced?** Yes No
 If **No**, skip questions 4-6.
 If **Yes**, answer 4-6.

4. **What type of custodial agreement do you have?** _____

5. **Does the other parent/guardian consent that your child can participate in services?** Yes No

6. **Do you have the ability to make medical decisions without the other parent's consent?** Yes No
 If **Yes**, please provide a copy of the **court paperwork** that gives you this right.
 If **No**, please provide the **contact information** (phone and address) for the other parent.

Please note: Your child may not be able to be seen for any future appointments until their other parent or guardian has provided written or verbal consent allowing him or her to engage in treatment at Provident. For separated or divorced parents who have shared custody and shared ability to make medical decisions regarding a child's medical treatment, both parents' consents are required for the child to engage in services at Provident.

For Provident Staff only:

a. Parent not accompanying child to session has provided **verbal consent?** Yes No N/A

Date Verbal Consent Expressed: _____ / _____ / _____

Verbal Consent Obtained via: Phone Other: _____

Signature of Staff Verifying Verbal Consent Provided: _____

b. Parent not accompanying child to session has provided **written consent?** Yes No N/A

Original Signature Page from other parent in file: _____ / _____ / _____

Signature of Staff Verifying Written Consent Provided: _____



Client ID#: _____
Last Name: _____
Date Scanned to EHR: ___/___/___
Scanned by: _____

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Parent Questionnaire

Child's Name: _____ Age: _____ Home Phone: _____
First, Middle, and Last Name

Nicknames: _____ Parent's Work Phone: _____

Street Address: _____ Cell/Other #: _____

Apt #: _____ Date of Birth: _____ Email: _____

City: _____ State: _____ Social Security #: _____ - _____ - _____

Zip Code: _____ Child's Gender: Male Female Other: _____

Race/Ethnicity: African American Caucasian Asian Native American/Alaskan Native
 Hispanic/Latino Biracial/Multiracial Other: _____

Child's Sexual Orientation: Heterosexual/Straight Lesbian/Gay Bisexual Questioning

Who referred you to Provident? _____

PRESENTING CONCERNS

What problems or concerns bring you and your child to Provident today? (Include when problem began, how often, triggers, etc.)

What do you hope to accomplish through counseling?

FAMILY INFORMATION

Child's Mother: _____

Child's Father: _____

Date of Birth: ___/___/___

Date of Birth: ___/___/___

Education: _____

Education: _____

Occupation: _____

Occupation: _____

Marital Status of Child's Parents (select all that apply):

- Married Never Married Separated Divorced Living Together
 Mother Remarried Father Remarried Parent Deceased Other: _____

If parents are divorced or separated:

Who has legal custody? _____

Who has financial responsibility? _____

Is there court mandated child support? Yes No

If yes, is it paid regularly? Yes No

Do You Live In an: Apartment House Other: _____ Do you: Rent Own

Annual Family/Household Income: \$ _____

Do you use assistance to pay utility bills or other expenses? Yes No If yes, explain: _____

Is there enough food and clothing in the household? Yes No

What is your living situation? Stable Unstable Homeless Dangerous or Hazardous

Total # of people living in the household: _____



FAMILY INFORMATION (cont.)

With whom does your child live?

Name of Household Member	Age	Relationship to Child

SCHOOL HISTORY

Child's School: _____ Grade: _____ Teacher: _____

Is your child attending: Regular Classroom Regular Class & Resource Room Learning Disabilities Classroom
 Special Class Behavior Disabilities Classroom Other: _____

Has your child ever been suspended from school? Yes No Once Infrequently Frequently

Has the child ever changed schools or school districts? Yes No If Yes, why? _____

Has your child had an Individualized Education Program (IEP)? Yes No If Yes, when? _____

Has your child ever repeated a grade? Yes No If Yes, what grade(s)? _____

Has your child been attending school regularly? Yes No If No, why? _____

Has your child ever been fearful or reluctant to attend school? Yes No If Yes, when? _____

Does your child complete his or her homework regularly? Yes No

Does your child require help completing homework? Yes No

Does your child have behavior or academic problems at school? Yes No

If Yes, explain: _____

WORK HISTORY

Does your child have a job? Yes No

If Yes: Job Title: _____ Employer: _____ Hours Worked Weekly: _____

PEER RELATIONSHIPS

Does your child seek friendships? Yes No

Is your child sought by peers for friendships? Yes No

Does your child play with children his or her own age? Yes No Younger Older

Is your child having problems with friends or in social situations? Yes No

If Yes, explain: _____

My child's support system includes: Many friends and family few friends or family no support system

HOME BEHAVIOR

Who ordinarily disciplines your child? Mother Father Both Parents Other: _____

What techniques do you use to discipline your child? _____

Have these methods been effective? Yes No

How well does your child get along with his or her brothers and sisters?

Very Well Average Arguments Avoids Frequent Fights Jealousy Is Teased Teases

Does your child share a bedroom? Yes No If yes, with whom? _____



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Does your child experience any sleep problems (ex. difficulty falling or staying asleep, problematic dreams)? Yes No

If Yes, explain: _____

Has your child had any changes in appetite? Yes No

If Yes, explain: _____

Has your child had any frightening or traumatic experiences? Yes No

If Yes, explain: _____

Have you ever been involved with Children's Services (DFS, DCFS, Children's Division)? Yes No

If Yes, explain: _____

Has anyone been physically or sexually abusive to your child? Yes No

If Yes, please describe _____

Has your child witnessed physical or sexual violence? Yes No

If Yes, please describe: _____

LEGAL HISTORY

Has your child ever been arrested? Yes No

If Yes, why? _____

Has your child ever been convicted of a crime? Yes No

If Yes, what was the charge(s)? _____

Is your child under court supervision or required to meet with a Juvenile Officer (DJO)? Yes No

SUBSTANCE USE HISTORY

Does your child smoke cigarettes? Yes No If Yes, how much/how often? _____

To your knowledge, has your child ever used alcohol or drugs? Yes No

If Yes, please describe (include substance is used & how often): _____

MENTAL HEALTH HISTORY

Has your child had previous counseling, psychotherapy, or psychiatric care? Yes No

If Yes, describe past treatment dates, services received, medications prescribed, & previous diagnoses.

What traumatic or difficult events has your child experienced? _____

Have any immediate family members experienced mental health issues or participated in treatment? Yes No

If Yes, please describe relation to child, diagnosis/problem, and any treatment received.

ADDITIONAL HISTORY

What activities/hobbies/interests does your child enjoy? _____

Who does your child depend upon for emotional support? _____

Does your child use community resources or self-help groups? _____

What is your child's religious background? _____

Is your child active in these spiritual practices? Yes No



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MEDICAL HISTORY

Child's Current Height: _____ Current Weight: _____ Date of Last Exam: ____/____/____

Primary Care Physician: _____ Telephone #: _____

Length of Pregnancy: Full Term Premature (____ weeks)

Complications, illness or accidents during pregnancy, birth, or infancy? Yes No

If Yes, explain: _____

Alcohol or drug use during pregnancy? Yes No

Were developmental milestones (sitting, walking, talking, potty training): Early Normal Late

Describe skills developed late or early: _____

Indicate which of the following medical conditions **currently** affect your child:

- | | | | | |
|------------------------------------------------|--------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Birth Defects |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chest Pain/Pressure | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Difficulty Speaking | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Ear Pain | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fever/Chills/Sweats | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Kidney Disease/Dialysis | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Stomach Pain/Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Weight Change (loss/gain) | <input type="checkbox"/> Difficulty Walking/Coordinating Movements | |
| <input type="checkbox"/> Other: _____ | | | | |

Is your child currently being treated for the medical conditions listed above? Yes No

Describe any history of serious medical conditions, illnesses, or surgeries: _____

Please list any allergies your child has (food, medication, seasonal, etc.): _____

Is your child current with immunizations? Yes No If No, explain: _____

Current Medications: Please list all prescriptions, over the counter medications, and supplements your child is currently taking.*

Medication Name	Dosage/Frequency	Start Date	Prescribing Physician	Side Effects

Does your child take the medicine as prescribed? Yes No *attach medication list, if needed

Nutritional Screen	YES	NO
My child has an illness or condition that made me change the kind and/or amount of food they eat.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
My child eats fewer than 2 meals per day.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
My child eats TOO FEW fruits or vegetables or milk products.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
My child has tooth or mouth problems that make it hard for them to eat.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
My child doesn't always have enough money to buy the food they need.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
My child takes 3 or more different prescribed or over-the-counter drugs a day.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
My child, without wanting to, has lost or gained 10 pounds in the last 6 months.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

On a scale of 1 to 10, what is the present level of **physical** pain your child is experiencing?

0	1	2	3	4	5	6	7	8	9	10
No Pain										Extreme Pain

Specify Location of Pain: Muscular Joint Neck Back Other: _____

Does the pain your child experiences affect his/her daily activities? Yes No



Pediatric Symptom Checklist (PSC) – Parent Version

Child's Name: _____ Completed by: _____ Date: _____

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

		Never (0)	Sometimes (1)	Often (2)
1. Complains of aches/pains	1	_____	_____	_____
2. Spends more time alone	2	_____	_____	_____
3. Tires easily, has little energy	3	_____	_____	_____
4. Fidgety, unable to sit still	4	_____	_____	_____
5. Has trouble with a teacher	5	_____	_____	_____
6. Less interested in school	6	_____	_____	_____
7. Acts as if driven by a motor	7	_____	_____	_____
8. Daydreams too much	8	_____	_____	_____
9. Distracted easily	9	_____	_____	_____
10. Is afraid of new situations	10	_____	_____	_____
11. Feels sad, unhappy	11	_____	_____	_____
12. Is irritable, angry	12	_____	_____	_____
13. Feels hopeless	13	_____	_____	_____
14. Has trouble concentrating	14	_____	_____	_____
15. Less interest in friends	15	_____	_____	_____
16. Fights with others	16	_____	_____	_____
17. Absent from school	17	_____	_____	_____
18. School grades dropping	18	_____	_____	_____
19. Is down on him or herself	19	_____	_____	_____
20. Visits doctor with doctor finding nothing wrong	20	_____	_____	_____
21. Has trouble sleeping	21	_____	_____	_____
22. Worries a lot	22	_____	_____	_____
23. Wants to be with you more than before	23	_____	_____	_____
24. Feels he or she is bad	24	_____	_____	_____
25. Takes unnecessary risks	25	_____	_____	_____
26. Gets hurt frequently	26	_____	_____	_____
27. Seems to be having less fun	27	_____	_____	_____
28. Acts younger than children his or her age	28	_____	_____	_____
29. Does not listen to rules	29	_____	_____	_____
30. Does not show feelings	30	_____	_____	_____
31. Does not understand other people's feelings	31	_____	_____	_____
32. Teases others	32	_____	_____	_____
33. Blames others for his or her troubles	33	_____	_____	_____
34. Takes things that do not belong to him or her	34	_____	_____	_____
35. Refuses to share	35	_____	_____	_____

Total Score: _____



Counseling Attendance Policy

Effective Date: 7/1/2017

Welcome to Provident. We are glad you have chosen us for your counseling needs. As we are committed to dedicating time to you for your counseling sessions, it is also necessary that you are committed to attending your scheduled appointment times, too.

We ask the following of our clients:

- Please call 24 hours in advance to cancel or reschedule your appointment as appointments that are not cancelled more than 24 hours in advance or that you don't attend may be subject to a **no show fee**.
- If you miss two consecutive appointments without cancelling 24 hour or more in advance, services can be discontinued.
- A pattern of missed appointments (3 within a 6 month period), even if cancelled within 24 hours, may lead to termination of services and referral to another provider. Referrals to other counseling services are available upon request.
- Please arrive on time for all of your sessions. Sessions are generally scheduled for 1 hour. If you are late, you will only be seen for the remaining appointment time.

Your signature below indicates that you have read and understand Provident's attendance policy.

Client Name (Print)

Client/Guardian Signature

Date