Administrative Office
2650 Olive Street
St. Louis, Missouri 63103
314-371-6500

# CHILD INTAKE PACKET

Welcome to Provident Behavioral Health! Please complete the attached forms to begin services with our team of behavioral health professionals.

**You have been scheduled with: _____**

**Clinician Name & Credentials**

## Crisis Services

At Provident, you have access to a team of crisis workers 24/7/365. During regular office hours, please call the office where you receive services and ask to speak to your provider if you are in crisis or need immediate assistance. If available, a member of your treatment team will speak with you and assist you. Should your provider be unavailable, another staff will assist you or you will be linked with a Provident Crisis Worker.

**After-Hours Crisis Calls for Child Clients:** Please call **314-446-2874** for Provident's Crisis Workers for support at any time. Services are available 24 hours a day. In the event that the nature of the emergency is such that you require immediate attention, please call 988 for the National Suicide Prevention Lifeline, call 911, or go to the emergency room nearest you.

## Consent to Treatment

- I have chosen to receive behavioral health services from Provident. Services include, but are not limited to, Psychiatric Evaluation, Mental Health Assessment, Medication Management, Case Management, Psychoeducation, and Individual, Family, and Group Therapies.
- I understand that there are both risks and benefits associated with treatment, including side effects from medications that are prescribed.
- I understand that treatment 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 treatment, 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 treatment team.
- 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 treatment 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 services 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 1-5, sign the corresponding sections of the Signature Page (pg. 6) or electronic consent.**

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## 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 your 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 provider 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 provider 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 Clinical Director. The Clinical Supervisor or Clinical Director will speak with the client and investigate on behalf of the griever, if necessary. A written statement of results will be given to the griever/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 **Clinical Director** at 314-371-6500. Furthermore, you can contact **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 provider 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 at the time services are rendered.
- 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 1-5, sign the corresponding sections of the Signature Page (pg. 6) or electronic consent.**

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## Subpoena Policy

The role of Provident staff is to provide behavioral health treatment 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 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.

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# 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 Behavioral Health (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 1-5, sign the corresponding sections of the Signature Page (pg. 6) or electronic consent.**

Provident Behavioral Health

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## 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 provider(s) is the cornerstone of a therapeutic relationship. 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, psychiatric mental health nurse practitioners, medical assistants, collaborating psychiatrists, 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 or interventions are conducted in public settings, 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 or third-party funding source implies consent by the client that information regarding diagnosis, treatment plan, and clinical information may be disclosed to your insurance company or funding source 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 1-5, sign the corresponding sections of the Signature Page (pg. 6) or electronic consent.**

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## Client Fee Information

1. Each appointment we have available is an opportunity for our team to help a person or family in need. Appointments missed or cancelled less than 24 hours in advance will result in a fee (**$20 for Counseling & $50 for Psychiatry**). Please notify us well in advance if you cannot attend an appointment so that someone else can be seen during that time.
2. Payment is expected at the time services are provided. If you are unable to pay your sessions fees or copayments at the time of service, your appointment may be rescheduled.
3. All prepaid assessment fees are non-refundable.
4. Insurance and income verification must be submitted prior to or at the first appointment.
5. The client seeking services or parent/guardian seeking services for minor children is responsible for all fees not paid by insurance.
6. 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.
7. 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.
8. 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 and household size. Proof of income must be provided in order to be assigned a reduced fee for self-pay services.
9. If a client chooses not to use insurance, the standard out-of-pocket rate is required for all services.
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 our **Relations Coordinator at 314-802-2647**.

**After reading pages 1-5, sign the corresponding sections of the Signature Page (pg. 6) or electronic consent.**

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## Consent to Telehealth Services

Provident offers telehealth appointments, which use video conferencing to meet with your provider without being in the office. Telehealth is available to clients with video conferencing capabilities on their smart phone, computer, or tablet with webcam and microphone, as well as strong internet connectivity that supports participating in a video conference with good audio and video quality.

By participating in telehealth services with Provident, you are indicating consent to receive services delivered via video conference. Provident uses a HIPAA compliant account and has a Business Associate Agreement with Zoom, the video conferencing software company. There are advantages, disadvantages, and limitations regarding the security of confidential information when utilizing telehealth, which will be discussed with your provider. Provident's providers work to maintain the same level of care and professionalism that you would receive during an office-based visit. Your consent also indicates that you will, to the best of your ability, participate in your telehealth service in a confidential space in your own home to provide yourself the best atmosphere for your appointments.

**After reading pages 1-5, sign the corresponding sections of the Signature Page (pg. 6) or electronic consent.**

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## Telehealth Appointment Instructions

**To prepare for your telehealth appointment:**

1. Download the Zoom app to your device (smart phone, tablet, computer)
2. Allow the Zoom app to access to your camera and microphone to enable audio and video for telehealth.
3. **New Clients:** Complete your Consent Forms, Intake Survey, and any other forms assigned to you in your ClinicTracker Patient Portal. A link to verify your Patient Portal account will be sent from ClinicTracker, our electronic health record software company. Please check your junk mail if you do not see the verification email in your inbox.
4. Locate a quiet, confidential space in your home to participate in your telehealth session. Minimize distractions as much as possible. This time is for you!
5. **To join your appointment:** Access the Zoom meeting link in your Patient Portal Message or email. ***Copy and paste the link in your web browser.***
6. If you have not received your Zoom meeting link for your appointment, please contact the front desk at the site where your provider works:
    - **Counseling: St. Louis City (Olive Street):** 314-371-6500
    - **Counseling: Creve Coeur (Ladue Road):** 314-878-4340
    - **Counseling: South (Tesson Ferry Road):** 314-898-0102
    - **Psychiatric Services:** 314-802-2670

PBH Patient Portal

Provident Behavioral Health

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## Signature Page

**Child's Name: _____ Birth Date: __/__/_____ Parent's Name(s): _____**
*First, Middle, & Last*

**Contact Information:**

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Email: _____

Provident may contact me and leave a message by (check all that apply): ☐ Voicemail ☐ US Mail ☐ Text Message
☐ **Please do not** contact me in the following ways: _____

**In the case of any emergency, please notify:**

Name: _____ Relationship: _____ Phone: _____

☐ Address same as client Address: _____ City: _____ State: _____ Zip: _____

### Consent to Treatment

I have reviewed the Consent to Treatment policies, they have been explained to me, and I understand them. I request services from Provident.

Client/Guardian Signature: _____ Date: _____

_____ Date: _____

Witness Signature: _____ Date: _____

### Client Rights and Responsibilities

I have reviewed the Client Rights and Responsibilities policies, they has been explained to me, and I understand them.

Client/Guardian Signature: _____ Date: _____

_____ Date: _____

Witness Signature: _____ Date: _____

### Notice of Privacy Practice

I have reviewed the Notice of Privacy Practice policies, they have 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: _____ Date: _____

_____ Date: _____

Witness Signature: _____ Date: _____

### Statement of Confidentiality

I have reviewed and understand the Statement of Confidentiality policy and understand the extent to which Provident is permitted to disclose information about me.

Client/Guardian Signature: _____ Date: _____

_____ Date: _____

Witness Signature: _____ Date: _____

### Client Fee Information

I have reviewed the Client Fee Information policy, it has been explained to me, and I understand the fees associated with services and missed appointments.

Client/Guardian Signature: _____ Date: _____

_____ Date: _____

Witness Signature: _____ Date: _____

### Consent to Telehealth Services

I have reviewed and understand the Consent to Telehealth Services and consent to participate in telehealth services, when appropriate and available.

Client/Guardian Signature: _____ Date: _____

_____ Date: _____

Witness Signature: _____ Date: _____

Provident Behavioral Health

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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 Primary Insurance Company: _____ ID#: _____ Group ID: _____
Insurance Card Holder Name: _____ Copay: $_____ Deductible: $_____

Name of Secondary Insurance Company: _____ ID#: _____ Group ID: _____
Insurance Card Holder Name: _____ Copay: $_____ Deductible: $_____

**Employment Information:** ☐ I am employed ☐ I am not employed

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

| Gross Household Income | | |
|---|---|---|
| **Family Member** | **Employer Name** | **Annual Income** |
| **Self:** | | $ |
| **Significant Other** (if living together)**:** | | $ |
| **Other Family Members in Household:** | | $ |
| **Child Support/Alimony Received** (annual amount): | | $ |
| If you did not file a Tax Return, please note Annual Gross Income (before taxes): | | $ |
| **Total Annual Gross Household Income:** | | $ |
| **Total # of people living in household (including yourself):** | | |
| Fee amount for Self-Pay Services is based on Total Gross Household Income and household size. 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. | **Counseling**<br>Mental Health Assessment<br>Individual & Family Therapy<br><br>**Psychiatric Services**<br>Psychiatric Evaluation:<br>Follow Up/Medication Management: | **Max out of pocket fees**<br><br>$140<br>$140<br><br><br>$240<br>$150 |

**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. **If insured: Insurance, Medicare, and Medicaid Cards** (front & back)
2. **If self-pay: IRS 1040 Tax Return Form or 2 most recent Paycheck Stubs, Benefit Statement** (for Unemployment or Social Security Disability), or other proof of income.

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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:** _____

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

1. **Are you the child's sole legal guardian(s)?** ☐ 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 ☐ I am child's only parent (other parent deceased or has never been involved)
   If **No/parents still together or you are your child's only parent**, skip questions 4-6. No additional information.
   If **Yes**, please answer questions 4-6.

4. **If not together, 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:** It is in the best interest of the child that both of their parents support their involvement in treatment. If you and your child's other parent are no longer together and you do not have sole guardianship of your child, 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.

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**For Provident Staff only:**

Parent not accompanying child to session has provided **consent**? ☐ Yes ☐ No ☐ N/A
Type of Consent Obtained: ☐ Verbal ☐ Written
Date Consent Obtained: _____/_____/_____
Consent Obtained via: ☐ Phone ☐ Signed Consent Forms
☐ Other: _____

Guardianship Notes: _____

Signature of Staff Verifying Consent Provided: _____

Provident Behavioral Health

**Client Name:** _____
**DOB:** ___/___/____
**Date Completed:** ___/___/____

# Parent Questionnaire

Child's Legal Name: _____ Birth Date: ___/___/_____ Age: ____ Sex at Birth: ☐ Male ☐ Female

Preferred/Chosen Name: _____ Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Other: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Email: _____

Race/Ethnicity: ☐ Black or African American ☐ Caucasian ☐ Asian ☐ Hispanic/Latino ☐ Biracial/Multiracial
☐ Native American or Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ Other/Describe: _____

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

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 treatment? _____

_____

## FAMILY INFORMATION

**Primary Parent/Guardian 1:** _____ *Full name*
Relationship with child: ☐ Mother ☐ Father ☐ Grandparent ☐ Other:_____
Date of Birth: ____/____/_____
Education: _____
Occupation: _____

**Primary Parent/Guardian 2:** _____ *Full Name*
Relationship with child: ☐ Mother ☐ Father ☐ Grandparent ☐ Other:_____
Date of Birth: ____/____/_____
Education: _____
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

List any additional parental figures and their relationship to the child: _____

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

**Annual Family/Household Income: $_____** **Total # of people living in the household: _____**

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

With whom does your child live?

| Name of Household Member | Age | Relationship to Child |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Provident Behavioral Health

**Client Name:** _____
**DOB:** ___/___/____
**Date Completed:** ___/___/____

## SCHOOL HISTORY

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

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

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: _____

Provident Behavioral Health

**Client Name:** _____
**DOB:** ___/___/____
**Date Completed:** ___/___/____

Has your child had any frightening or traumatic experiences *(including accidents, losses, abuse, neglect, or exploitation)*? ☐ Yes ☐ No
If Yes, explain: _____

Have you ever been involved with Children's Services (DFS, DCFS, Children's Division)? ☐ Yes ☐ No
If Yes, explain: _____ ☐ Currently Involved

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 or use nicotine products? ☐ Yes ☐ No If Yes, how much/how often? _____
Does anyone in the home smoke/use nicotine products? ☐ Yes ☐ No If Yes, who? _____
Would you like information about smoking cessation? ☐ Yes ☐ No
To your knowledge, has your child ever used alcohol or drugs? ☐ Yes ☐ No

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

Is there any family history of drug or alcohol abuse? Please explain: _____

## 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 any religious or spiritual practices? ☐ Yes ☐ No Describe: _____

## MEDICAL HISTORY

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

Primary Care Provider: _____ Practice Name/Location: _____

Phone Number: _____ ☐ Provident can coordinate care with my primary care provider

Please list any other doctors or specialist you work with and what issues they are treating you for: _____
_____

Provident Behavioral Health

**Client Name:** _____
**DOB:** ___/___/____
**Date Completed:** ___/___/____

## MEDICAL HISTORY (continued)

Length of Pregnancy: ☐ Full Term ☐ Premature ( ____ weeks) Alcohol/drug use during pregnancy? ☐ Yes ☐ No

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

If Yes, explain: _____

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:

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

☐ 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: _____

Family history of medical issues *(include medical issue and family member relationship):* _____

**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

**Pain Screen:** On a scale of 1 to 10, what is the present level of **physical** pain your child is experiencing? *(circle one)*

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

Location of Pain: ☐ Muscular ☐ Joint ☐ Neck ☐ Back ☐ Other: _____
Does your child's pain affect his/her daily activities? ☐ Yes ☐ No

**Nutrition Screen:** *Please answer the following about your child's nutritional habits. Please explain any items marked "yes".*

| Yes | No | My child… | Explanation: |
|---|---|---|---|
| 1 | 0 | 1. Has had a decreased appetite/has been eating less than normal. | Decreased appetite has lasted for: ____ **(#) days/weeks/months** |
| 1 | 0 | 2. Has lost or gained at least 10 pounds in the last **3** months. | _____ pounds ☐ gained ☐ lost |
| 1 | 0 | 3. Has an allergy, illness, or condition impacts how they eat. | Explain: |
| 1 | 0 | 4. Requires a special diet. | Explain why special diet is needed and if child adheres to diet: |
| 1 | 0 | 5. Has dental problems that make it hard to eat.* | Describe tooth or mouth pain/problems: |
| 1 | 0 | 6. Eats fewer than 2 meals per day. | |
| 1 | 0 | 7. Eats too few fruits or vegetables or milk products. | |
| 1 | 0 | 8. Our family does not always have enough money to buy the food our child needs.** | |
| 1 | 0 | 9. Has been binge eating (eating large quantities of food at once). | |
| 1 | 0 | 10. Has been forcing himself/herself to vomit after eating. | |
| 1 | 0 | 11. Has been excessively active to burn off calories consumed. | |
| 1 | 0 | 12. Has been concerned with weight and/or restricting calories. | |
| **Total Score:** | | **Score Interpretation:** Scores of 4-7 = use clinical judgement to determine referral needs. Scores of 8+ = refer to doctor, nutritionist, or other appropriate resource(s). *Refer to dental care if dental problems are noted. **Refer to resources for food if family needs assistance. | |

Provident Behavioral Health

Administrative Office
2650 Olive Street
St. Louis, Missouri 63103
314-371-6500

# 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 themselves | 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 they are 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 their 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 their troubles | 33 | _____ | _____ | _____ |
| 34. Takes things that do not belong to them | 34 | _____ | _____ | _____ |
| 35. Refuses to share | 35 | _____ | _____ | _____ |

**Total Score:** _____

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# Kidscreen-10 Index: Health Questionnaire for Children and Young People

**Client Name** *(first & last)*: _____ **Date: ___/___/_____** **Age: ____**

**Completed by:** ☐ Client/Self ☐ Parent/Guardian ☐ Other (specify): _____

Hello,
How are you? How do you feel? This is what we would like you to tell us.

Please read every question carefully. What answer comes to your mind first? Choose the box that fits your answer best and cross it.

Remember: This is not a test so there are no wrong answers. It is important that you answer all the questions and also that we can see your marks clearly.

**When you think of your answer please try to remember the last week.**

**Thinking about the last week…**

| | | | | | |
|---|---|---|---|---|---|
| 1. Have you physically felt fit and well? | Not at all ☐ | Slightly ☐ | Moderately ☐ | Very ☐ | Extremely ☐ |
| 2. Have you felt full of energy? | Never ☐ | Almost never ☐ | Sometimes ☐ | Almost Always ☐ | Always ☐ |
| 3. Have you felt sad? | Never ☐ | Almost never ☐ | Sometimes ☐ | Almost Always ☐ | Always ☐ |
| 4. Have you felt lonely? | Never ☐ | Almost never ☐ | Sometimes ☐ | Almost Always ☐ | Always ☐ |
| 5. Have you had enough time for yourself? | Never ☐ | Almost never ☐ | Sometimes ☐ | Almost Always ☐ | Always ☐ |
| 6. Have you been able to do the things that you want to do in your free time? | Never ☐ | Almost never ☐ | Sometimes ☐ | Almost Always ☐ | Always ☐ |
| 7. Have your parent(s)/guardian(s) treated you fairly? | Never ☐ | Almost never ☐ | Sometimes ☐ | Almost Always ☐ | Always ☐ |
| 8. Have you had fun with your friends? | Never ☐ | Almost never ☐ | Sometimes ☐ | Almost Always ☐ | Always ☐ |
| 9. Have you got on well at school? | Not at all ☐ | Slightly ☐ | Moderately ☐ | Very ☐ | Extremely ☐ |
| 10. Have you been able to pay attention? | Never ☐ | Almost never ☐ | Sometimes ☐ | Almost Always ☐ | Always ☐ |

**In general, how would you say your health is?**

☐ excellent
☐ very good
☐ good
☐ fair
☐ poor