LIVING WELL CHRISTIAN FAMILY CLINIC --CONFIDENTIAL CONTACT FORM

Client Name: _____

Cell Phone _____ **E-mail** _____

Home Phone _____ **Address**_____

Other Phone _____ _____

Please describe any restrictions on the means and/or location you want us to use (e.g.- do not leave a message on home telephone number): _____

_____

_____

Appointment Reminders

As a courtesy, our office sends out appointment reminders prior to scheduled appointments. Our cancellation policy requires 24-hour notice for cancelling an appointment.

I prefer to receive my appointment reminders using:

text message ☐ _____

e-mail ☐ _____

I do **NOT** want to receive appointment reminders: ☐

Balance Notifications

Our office is transitioning to electronic notification of balances due on your account. This saves the expense of office printing and mailing paper statements.

These balance notifications contain a link sent to text message or e-mail. You must provide us the cell number and or e-mail you would like to use.

Upon clicking the link in your notification, you are taken to a payment portal where you can log in to see more information about your charges and payments.

I prefer to receive my balance notifications using:

text message ☐ _____

e-mail ☐ _____

I do **NOT** want to receive balance notifications, please mail me a paper statement: ☐

Signature: _____ **Date:** _____

If this request is by a personal representative on behalf of the individual (e.g.- minor child), complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Please refer to LWCFC Privacy Practice Notice for more information on confidential communication and HIPAA
10/22

Living Well Christian Family Clinic – Intake Form (Child)

CLIENT (MINOR CHILD)

Name: _____D.O.B _____ Race: _____
Street: _____ City: _____ Zip: _____
Home phone: _____ Cell: _____ Work: _____
Grade in School: _____ Employer: _____
Church: _____

PARENT/GUARDIAN 1

Name: _____D.O.B _____ Race: _____
Street: _____ City: _____ Zip: _____
Home phone: _____ Cell: _____ Work: _____
Education (highest level): _____
Employer: _____ Occupation: _____
How long at current employer:_____
Church: _____ Past Military Experience: _____

PARENT/GUARDIAN 2

Name: _____D.O.B _____ Race: _____
Street: _____ City: _____ Zip: _____
Home phone: _____ Cell: _____ Work: _____
Education (highest level): _____
Employer: _____ Occupation: _____
How long at current employer:_____
Church: _____ Past Military Experience: _____

FAMILY INFORMATION

Parent/Guardian Marital Status: _____

Describe relationships with parents or guardians:

_____
_____
_____

Siblings, Step-Siblings/Half-Siblings

Name	Age	Grade	Describe relationship

Living Well Christian Family Clinic – Health Report

Name: _____ Age: _____ DOB: _____

HEALTH HISTORY:

What childhood diseases did you have?

_____

_____

What serious illnesses have you had?

_____

_____

What operations have you had?

_____

_____

List present health concerns:

_____

_____

What allergies do you have?

_____

_____

Please list any prescription or over-the-counter medications you are currently taking and why:

Medication	Dosage (i.e.- 15ml)	Frequency (i.e.- 2x/day)	Purpose

When was your last physical check-up? _____ Results: _____

_____

_____

How is your appetite? _____

Have you lost weight in the last three months? Gained?

If you have gained or lost weight, how much? _____

How many hours do you sleep on an average night? _____

Do you have problems sleeping?

Do you exercise? If so, what do you do? _____

How often? _____

How many packs of cigarettes do you smoke each day? _____

How many caffeinated drinks do you consume each day (coffee, tea, soda, energy drinks)? _____

How many alcoholic drinks per week? _____

Are you using other substances?

_____

_____

Is there a history in your family of any of the following? _____

☐ Abuse/Trauma	☐ Depression	☐ Neurological Disease
☐ ADHD	☐ Diabetes	☐ Obesity
☐ Alcohol Abuse	☐ Eating Disorders	☐ Schizophrenia
☐ Anxiety	☐ Gallbladder Disease	☐ Seizures
☐ Arthritis	☐ Heart Disease	☐ Stroke
☐ Autism	☐ High Blood Pressure	☐ Substance Abuse
☐ Bipolar Disorder	☐ High Cholesterol	☐ Suicide
☐ Cancer	☐ Hypoglycemia	☐ Upper Respiratory Problems
☐ Dementia	☐ Intellectual Disability	

Other health issues: _____

_____

Name of your Personal Physician: _____ Phone: _____

Clinic Name: _____ Clinic Address: _____

City: _____ State: _____Zip: _____

May we contact your Physician?

PRESENTING CONCERN:

Why are you seeking therapy/counseling? _____

_____

_____

_____

_____

_____

MENTAL HEALTH OR SUBSTANCE ABUSE TREATMENT HISTORY:

Please list any prior mental health treatment or counseling (include any hospitalizations or substance abuse treatment):

Dates	Location	Provider	Reason/Outcome

What did you like/dislike about your former experiences with counseling? _____
_____
_____
_____
_____

EDUCATIONAL/VOCATIONAL ISSUES:

Highest Grade Completed: _____

Did you have any learning or behavioral problems while in school?
_____
_____

Are you experiencing any issues related to your job/schooling due to the concern you are being seen for today?
_____
_____
_____
_____

FAITH / SPIRITUALITY:

Do you have any concerns related to your spirituality or faith and the reason you are being seen today that you believe may impact your care?
_____
_____
_____
_____

STRESSORS:

Please list any changes in your life that you would consider to be significant in the past several years:
_____
_____
_____
_____

Have any of these had a negative or positive effect on your daily life? _____
_____
_____

How would you describe your financial situation?

_____

SOCIAL/LEISURE:

Are you satisfied with your current social life/social supports?

Please describe
_____
_____

What do you do to manage stress?

_____
_____

What do you enjoy doing in your spare time?

_____
_____

ADDITIONAL DETAILS:

Is there any additional information you would like to share with your therapist relevant to your treatment?

_____
_____
_____
_____

Have you been a victim or at risk for emotional, physical or sexual abuse?

If yes, please share any details you are comfortable disclosing at this time.

_____
_____
_____
_____

DSM-5-TR Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _____ **Age: ____** **Date:_____**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) have you…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** have you…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes		☐ No			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes		☐ No			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes		☐ No			
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes		☐ No			
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	☐ Yes		☐ No			
	25.	Have you EVER tried to kill yourself?	☐ Yes		☐ No			

DSM-5-TR Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age: ____** **Date:_____**

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

Rights of Minors: Outpatient Behavioral Health Treatment

Consent for Mental Health Treatment

If you are younger than 14-years-old, a parent or guardian must agree, in writing, to you receiving outpatient mental health treatment.

If you are 14 years or older, you and your parent or guardian must agree to you receiving outpatient mental health treatment.

If you want treatment but your parent or guardian is unable to agree to it or won't agree to it, you (or someone on your behalf) can petition the county mental health review officer for a review.

If you do not want treatment but your parent/guardian does, the treatment director for the clinic where you are receiving services must petition the mental health review officer for a review.

Regardless of your age, in an emergency, the treatment director for the clinic may allow you to receive outpatient mental health treatment, but no medication, for up to 30 days.

During the 30 days, the treatment director must get informed written consent of your parent or guardian, or file a petition for review for admission with the mental health review officer.

Consent for Substance Use Treatment

Any minor can consent to substance use treatment at a public facility as long as it is for prevention, intervention, or follow-up.

If you are younger than 12-years-old, you may only get limited substance use treatment (such as detox) without a parent or guardian's consent.

If you are 12 years or older, you can be provided some limited treatment (assessment, counseling, and detox less than 72 hours) without your parent or guardian's consent or knowledge.

If your parent or guardian agrees to it, you can be required to participate in substance use treatment, including assessment and testing.

Review by Mental Health Review Officer and/or Court

Each juvenile court appoints a mental health review officer for that county. www.dhs.wisconsin.gov/clientrights/mhro

The juvenile court must ensure assistance is provided in the petition for review.

If you request it and the mental health review officer believes it is in your best interests, review by the mental health review officer can be skipped and the review will be done by the court.

If the mental health officer does the review, a hearing must be held within 21 days of the filing of the petition for review. Everyone must get at least a 96-hour notice of the hearing.

To approve your treatment (against your will or despite the refusal of your parent/guardian), the mental health review officer must find that:

- The refusal of consent is unreasonable.
- You are in need of treatment.
- The treatment is appropriate and least restrictive for you.
- The treatment is in your best interests.

If you disagree with the decision of the mental health review officer, you and your parent/guardian will be informed of the right to a judicial review.

If the court does the review, within 21 days of the mental health review officer's ruling, you (or someone acting on your behalf) can petition the juvenile court for a judicial review.

A court hearing must be held within 21 days of the petition. Everyone must get at least a 96-hour notice of the hearing.

If you do not want the treatment, the court must appoint you an attorney at least 7 days prior to the hearing.

If it is your parent/guardian who does not want the treatment and you do not already have a lawyer, the court must appoint you one.

To approve your treatment (against your will or despite the refusal of your parent/guardian), the judge must find that:

- The refusal of consent is unreasonable.
- You are in need of treatment.
- The treatment is appropriate and least restrictive for you.
- The treatment is in your best interests.

A court ruling does not mean that you have a mental illness. The court's ruling can be appealed to the Wisconsin Court of Appeals.

Treatment Rights

You must be provided prompt and adequate treatment.

If you are 14 years or older, you can refuse mental health treatment until a court orders it.

You must be told about your treatment and care.

You have the right to and are encouraged to participate in the planning of your treatment and care.

You and your relatives must be informed of any costs they may have to pay for your treatment.

Personal Rights

You must be informed of your rights.

Reasonable decisions must be made about your treatment and care.

You cannot be treated unfairly because of your race, national origin, sex, gender expression, religion, disability, or sexual orientation.

Record Access and Privacy Rights

Staff must keep your treatment information private (confidential). However, it is possible that your parents may see your records.

If you are younger than 14-years-old, you must view your records in the presence of a parent/guardian, attorney, judge, or staff member. You may always see your records on any medications you take. Regardless of your age, staff may limit how much you may see of your records. They must give you reasons for any limits.

If you are at least 14-years-old, you can consent to releasing your own mental health treatment records to others.

If you are at least 12-years-old, you can consent to releasing your substance use treatment records to others.

Patient Rights Help

- Contact the client rights staff at your treatment provider.
- File a complaint. Client rights staff will look into your complaint.
- Contact Disability Rights Wisconsin at 800-928-8778. Their advocates and attorneys can help you with patient rights questions.

For More Information

Visit the DHS client rights website at: www.dhs.wisconsin.gov/clientrights/minors

WISCONSIN DEPARTMENT of HEALTH SERVICES

Division of Care and Treatment Services
P-20470BF (06/2021)