FOR OFFICE TO COMPLETE

Intake Date:_____

Practitioner:_____

Fee:$_____

CHILD/ADOLESCENT INFORMATION

Date Completed: _____

Person Completing Form and Relationship to Child: _____

- Child's Name: _____ If Teen, Ph #: _____

  If teen, may we send text reminders? No___ Yes-wireless provider:_____
- Date of Birth: _____ • Age: _____ • SS#: _____
- Place of Birth: _____ • Gender: _____
- Race: _____ • Primary Language: _____
- School: _____ • Grade: _____
- Primarily lives with (indicate relationship to child): _____
- Mother/Guardian's Information Name: _____

  ___ Biological mother ___ Step-mother ___ Adoptive mother ___ Foster mother

  ___ Grandmother ___ Other relative: _____ ___ Other: _____

  Address: _____
  Street City State Zip

  Phone numbers: Home ___ _____ Cell _____ Work _____

  May we leave a message? Yes___ No ___ Yes___ No ___ Yes___ No ___

  May we send txt reminders to cell ph? No___ Yes-wireless provider:_____

  Email (I consent to being added to email list): _____
- Father/Guardian's Information Name: _____

  ___ Biological father ___ Step-father ___ Adoptive father ___ Foster father

  ___ Grandfather ___ Other relative: _____ ___ Other: _____

  Address: _____
  Street City State Zip

  Phone numbers: Home _____ Cell _____ Work _____

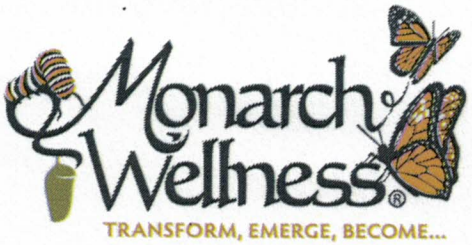
  May I leave a message? Yes___ No ___ Yes___ No ___ Yes___ No ___

  May we send txt reminders to cell ph? No___ Yes-wireless provider:_____

  Email (I consent to being added to email list): _____
- Other adults authorized to transport client to/from sessions & their relationship to child:

  _____
- How did you hear about our practice? _____
- For internet please indicate search engine/referring website if known: _____
- May I have your permission to thank this person/site for the referral? Yes___ No ___ N/A ___
- Please indicate any other agencies involved (eg. DCF, CCSO, Family Preservation Services, etc.):

  _____



POLICIES AND INFORMED CONSENT FOR PSYCHOTHERAPY

Welcome to Monarch Wellness®. We appreciate your giving us the opportunity to be of help to you. This document contains important information about our professional services and business policies and answers questions that clients often ask about therapy. Please read it carefully and feel free to ask any questions before signing. When signed, it will represent an agreement between us.

Mental Health Treatment

Psychotherapy and coaching are not easily described in general statements. It varies depending on the practitioner and client and the particular issues brought forward. Therapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the treatment to be successful, you will have to work on things we talk about both during our sessions and at home and remain open and honest throughout the process. Psychotherapy can have benefits and risks. Since it often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have many benefits. It often leads to improved relationships, solutions to specific issues, and significant reduction in feelings of distress. Be aware that there are no guarantees of what you will experience, and issues can appear to worsen before improving as they unfold. Treatment involves a large commitment of time, money, and energy, so it is important to be aware of the full process. If you have questions about our procedure, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another professional for a second opinion.

Confidentiality

In general, the law protects the privacy of all communications between a client and psychotherapist, and we can release information about our work to others only with your written permission. However, there are a few exceptions, as outlined further in the Notice of Privacy Policy. This includes mandatory reporting of suspected abuse or neglect of a child, elderly, or disabled person, protective actions of persons at risk of harm to self or others, and valid court orders requiring disclosure. Please see Monarch Wellness®' Notice of Privacy Policy for further information.

We also consult with colleagues and specialists at times. This pursuit of quality assurance never involves your name or any specifics through which you might be identified without your consent, and these professionals are also required to keep your information private. Minimally necessary information may also be disclosed to the Monarch Wellness® treatment team with the same purpose to provide the most effective care. If I am away from the office for an extended period of time, I may ask a colleague or Monarch Wellness® representative to be my back-up to be available to my clients in case of emergencies. Therefore, he or she needs to know about you and is bound by the same laws and rules as I am to protect your confidentiality. Further, if I must discontinue our relationship because of illness, disability, or other unforeseen circumstances, I ask you to agree to my transferring your records to another therapist who will assure their confidentiality, preservation, and appropriate access.

INITIALS OF CLIENT (OR GUARDIANS IF A MINOR) _____ _____

Meetings

Our first few sessions will involve an evaluation/assessment of your needs. During this time, we can both decide whether I am the best person to provide the services you need in order to meet your treatment goals. By the end of the evaluation, I will be able to offer you some first impressions of what our work may include and we will develop a treatment plan together including realistic goals, how often we will meet, and a target date for completion of treatment.

If psychotherapy is begun, we will usually schedule one session per week at a time we agree on; some sessions may be longer or more frequent depending on your needs. Some clients see us more frequently in the beginning stages and sessions taper off later to once a week or every other week. From time to time, we will review our progress towards the goals we have set. Once an appointment hour (typically 45 minutes) is scheduled, you will be expected to pay for it at the beginning of the session unless you provide at least 48 hours' advance notice of cancellation (unless we both agree that you were unable to attend due to illness or emergency). If possible, we will try to find another time to reschedule the appointment. If at any time you wish to stop therapy, we ask that you communicate your feelings openly and agree now to meet then for at least one more session to review our work together.

Minors

Our policy is to have both parents' consent prior to treatment. The only exception to this policy (at the discretion of the assigned therapist) is if you have a legal document granting one adult with 100% parental decision-making rights. If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to encourage parents to respect confidentiality of their child. However, we will provide information as necessary, particularly if there appears to be a risk of harm to yourself or someone else. I will discuss my concerns with you if possible before giving them any information, and I will do my best to handle any objections you may have about what I am prepared to discuss.

Your Rights

As a client, you have the right to terminate treatment at any time and request appropriate referrals. If at any time you want another professional's opinion or wish to consult with another therapist, we can assist you in finding an appropriate and qualified mental health professional of your choice. If needed in such a case, we can provide him or her with any essential information if you provide written consent. You also have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when we assess that releasing such information may be harmful in any way. Because they are professional records, they can be misinterpreted by and/or upsetting to untrained readers. If you wish to see your records, we recommend that you schedule an appointment to review them in our presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

You also have a right to be treated fairly and professionally. If you feel that you have not been treated accordingly and are unable to resolve the issue with me directly, you may present your concerns in writing to the attention of me and Monarch Wellness®. Although I am an independent contractor, Monarch Wellness® may be able to assist with resolving any concerns. If you have continued concerns or the matter is unresolved, you may file a complaint with the Florida Department of Health, further explained in the Monarch Wellness®' Notice of Privacy Policy.

INITIALS OF CLIENT (OR GUARDIANS IF A MINOR) _____ _____

Legal Proceedings

If you become involved in a legal divorce dispute, or other legal case, we want you to understand and agree that you and anyone representing you will not request us to testify in court, or disclosure of psychotherapy records. You should hire a different mental health professional for any evaluations or testimony you require. This position is based on the following reasons: (1) My statements will be seen as biased in your favor because we have a therapy relationship, (2) The testimony might affect my therapy relationship with you (and/or your child), and I must put this relationship first, thereby protecting the safety and confidentiality of therapy, and (3) There are other mental health professionals who specialize in court related cases and are more experienced and qualified than our practice.

Professional Relationship

As a professional, we will use our best knowledge and skills to help you. This includes following the ethical standards of the National Association of Social Workers (NASW), Association for Play Therapy (APT), American Counseling Association (ACA), American Association for Marriage and Family Therapy (AAMFT), American Psychological Association (APA), and Behavior Analyst Certification Board (BACB). In your best interests, they put limits on the relationship between a practitioner and a client, and we will abide by these; they are not personal responses to you. We are trained in the mental health field—not law, medicine, finance, or any other profession. We are not able to give you advice from these other professional viewpoints. State laws and rules of our profession require us to keep what you tell us confidential (that is, just between us), except in certain limited situations, as described further in the "Confidentiality" section of this packet and the Notice of Privacy Policy. If we meet on the street or socially, I may not say hello or talk to you very much in order to protect your privacy. Also, in your best interests and following professional standards, I can only be your therapist. I cannot have any other role in your life that may impair my objectivity, clinical judgment, therapeutic effectiveness, or can be exploitive in nature. I cannot, now or ever, be a close friend to or socialize with any of my clients. I cannot be a therapist to someone who is already a friend. I can never have a sexual or romantic relationship with any client during, or after, the course of therapy. I cannot have a business relationship with any of my clients, other than the therapy relationship.

Contacting Us

Therapists are often unavailable in between sessions, so if you need to talk to me directly before our next appointment, it is recommended to schedule an earlier session. You may also give the front office staff a specific message if you want to deliver to me before our next appointment. We are not always available to answer our office telephone (239) 231-3208. If no one is able to answer, our telephone is answered by a voicemail that we monitor frequently. Our front desk will make every effort to return your call on the same day you make it, or at least within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform us of times when you will be available. If you are unable to reach us and feel that you are in crisis and can't wait for us to return your call or for your next appointment, contact your family physician, 911, or the nearest emergency room and ask for the clinician/psychologist/psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary. By signing this document, you authorize a colleague or representative of Monarch Wellness® to contact you regarding any appointment changes, including if there were any emergency related to me. To ensure confidentiality, our office does not typically communicate with clients individually via email, social media, or text messages (with the exception of courtesy text reminders with your consent, which are automatically sent by our software system).

INITIALS OF CLIENT (OR GUARDIANS IF A MINOR) _____ _____

Supervision

If your practitioner is a Life Coach, Registered Clinical Social Work, Marriage and Family Therapy, or Mental Health Counseling Intern working towards licensure, it has been disclosed and you are fully aware of this status. If your practitioner is a registered intern during this time, he or she will be supervised by a licensed supervisor on or off site, which will be disclosed to you. Confidentiality pertaining to your information will be maintained to ensure that you are receiving the highest quality of services.

Monarch Wellness®

Therapists and other individual practitioners are independent contractors, and thus operate independently of Monarch Therapy LLC dba Monarch Wellness®. Monarch Wellness® does not control the manner or methods by which therapists and other practitioners provide services to clients. To that end, Monarch Wellness® and its owner are not legally responsible for your treatment. By signing this document, you knowingly, voluntarily, and expressly waive, and covenant not to sue for, any claim that you may have against Monarch Therapy LLC dba Monarch Wellness®, its owner/s of operation and staff, regardless of whether that claim may exist now or arise only in the future, whether it is based on past or future acts or omissions, whether it is foreseen or unforeseen, known or unknown, and whether it is based on anyone's negligence, including but not limited to the negligence of Monarch Therapy LLC dba Monarch Wellness®, its owner/s, or staff. You further agree to indemnify, defend and hold harmless Monarch Therapy, LLC dba Monarch Wellness®, its owner/s and staff from and against all claims arising out of or resulting from your participation in therapy. Although the individual practitioners are independent contractors, Monarch Wellness® works hard to refer you to, and/or otherwise facilitate your, high quality care with trained and experienced professionals with specific specializations. However, Monarch Wellness® makes no guarantee or warranty with respect to any practitioner or the services he or she will provide.

I have read the above Contract carefully and understand that I have the right to not sign this form. I had the opportunity to ask questions or gain clarification on anything I did not understand and know that I can also ask questions throughout treatment. I understand the policies and procedures, including my rights & responsibilities as a client, and the limitations of liability of the Monarch Wellness® practice. I consent to treatment with this practitioner, and agree to cooperate fully to the best of my abilities. I understand that I can discontinue services at any time and can also request a copy of these policies and procedures.

PRINTED NAME OF CLIENT	CLIENT SIGNATURE	DATE
PRINTED NAME OF PARENT/GUARDIAN	PARENT/GUARDIAN SIGNATURE	DATE
PRINTED NAME OF OTHER PARENT/GUARDIAN	OTHER PARENT/GUARDIAN SIGNATURE	DATE

I, the provider, have met with this client (and/or his or her parent/guardian) for a suitable period of time, and have informed him or her of policies in this brochure. I have responded to all of his or her questions. I believe this person fully understands the guidelines, and I find no reason to believe this person is not fully competent to give informed consent to treatment. I agree to enter into therapy with the client, as shown by my signature here.

PRINTED NAME OF PRACTITIONER	PRACTITIONER SIGNATURE	DATE

HIPAA PRIVACY NOTICE CONSENT

I, _____ certify that I have received and reviewed the Monarch
(Client or Legal Guardian)
Therapy LLC (dba Monarch Wellness®) Notice of Privacy Policy and I understand that my Protected Health Information (PHI) may be used for counseling services and other health operations as described in the Privacy Statement. I also understand the circumstances that would warrant using my health information and that I have the right to withhold consent in writing if I do not want information released for any purpose other than the legal requirements specified in the Monarch Wellness® Privacy Policy. I further understand that I may obtain additional copies by requesting them from my therapist.

I wish to be contacted in the following ways:

(Please check all that apply)	May we leave a message? (Please check)	
___Home Phone:_____	Yes_____	No_____
___Cell Phone:_____	Yes_____	No_____
___Work Phone:_____	Yes_____	No_____

___By mail at my home address:_____

_____ _____ _____
Printed Name of Client **Client Signature** **Date**

For Parent/Guardian of Minor: I am the legal parent/guardian of _____ and I may legally receive information regarding my child's counseling care within the limitations of confidentiality.

_____ _____ _____
Printed Name of Parent/Guardian **Parent/Guardian Signature** **Date**

_____ _____ _____
Printed Name of Other Parent/Guardian **Other Parent/Guardian Signature** **Date**

Notice of HIPAA Privacy Policy *(CLIENT COPY)*

Tel: (239) 231-3208 ~ www.MonarchWellness.net

Confidentiality

Monarch Therapy LLC dba Monarch Wellness is committed to protecting medical information about you. No information is released without your knowledge and written consent except for those rare instance where therapists are required by law or by court to reveal particular information. In an emergency situation where clients demonstrate a high probability of harming themselves or others, the staff may be required to release information to ensure safety. We are also mandated reporters of suspected abuse or neglect of minors, disabled, and elderly individuals, as described further below. This notice describes how medical information about you or your child may be used and disclosed by Monarch Wellness and how you can get access to this information. Please review this notice carefully.

Understanding Your Protected Health Information (PHI)

When you visit us, a record is made of you/your child's issues, assessment, recommendations, treatment plan, and other mental health or medical information. Your record is the physical property of Monarch Wellness; the information which is within, belongs to you. Being aware of what is in your record will help you to make more informed decisions when authorizing disclosure to others. In using and disclosing your protected health information (PHI), it is our objective to follow the Privacy Standards of the Federal Health Insurance Portability and Accountability Act (HIPAA) and requirements of Florida law.

Your mental health and/or medical records serve as:

- A basis for planning your counseling
- A legal document describing the counseling care you receive
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Responsibilities of Monarch Wellness

We are required to:

- Maintain the privacy of your protected health information (PHI) as required by law and provide you with notice of our legal duties and privacy practices with respect to the protected health information that we collect and maintain about you. This also applies to you and any other member of your family that participates in the counseling process aimed to help you/your child.
- Abide by the terms of this notice currently in effect. We have the right to change our notice of privacy practices and to make the new provisions effective for all protected health information that we maintain, including that obtained prior to the change. Should our information practices change, we will post new changes in the office, on the website, and provide you with a copy.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests to communicate with you about protected health information by alternative means. For example, you may not want a family member to know that you are participating in counseling. Upon your request, we will communicate with you, if needed, at a different time or via other means of communication.
- Use or disclose your health information only with your authorization except as described in this notice.

Your Protected Health Information (PHI) Rights

You have the right to:

- Review and obtain a paper copy of the notice of information practices upon request and of your health information, except that you are not entitled to access, or to obtain a copy of your medical records upon written request.
- Request and provide written authorization and permission to release information for purposes of outside treatment and health care operations. This authorization excludes psychotherapy notes and any audio/video tapes that may have been made with your permission.
- Revoke your authorization in writing at any time to use, disclose, or restrict health information except to the extent that action has already been taken.
- Request a restriction on certain uses and disclosures of protected health information, but we are not required to agree to the restriction request. You should address your restriction request in writing to your therapist at Monarch Wellness. We will notify you within 10 days if we cannot agree to the restriction.
- Request that we amend your health information by submitting a written request with the reasons supporting the request to your therapist. We are not required to agree to the requested amendment.
- Request confidential communications of your health information by alternative means, such as only at home or only by mail.

Disclosures for Treatment and Health Operations

I. Monarch Wellness will use your PHI, *with your consent*, in the following circumstances:

- **Counseling:** Information obtained by your therapist will be recorded in your record and used to determine the management and coordination of services that will be provided for you. This also applies to family counseling, group therapy, and behavior analysis.
- **Disclosure to others outside Monarch Wellness:** If you give us a written authorization; you may revoke it in writing at any time but that

revocation will not affect any use or disclosures permitted by your authorization while it was in effect. We will not use or disclose your health information without your authorization, except (as described below) to report serious threat to health or safety or child and adult abuse or neglect.

- **To you or legal guardian:** Upon your request, we will disclose your health information to you. If you authorize us to do so, we may use your or your health information or disclose it to the person or entity you name on your signed authorization. Once you provide us with an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. In certain situations, when disclosure of your or your child's information could be harmful for you or another person, we may limit the information available to you, or use an alternative means of meeting your request.
- **Your family and friends:** If you are unable to consent to the disclosure of your or your child's health information, such as in a medical emergency, we may disclose your or your child's personal information to a family member or friend to the extent necessary to help with your or your child's health care. We will only do so if we determine that the disclosure is in you/your child's best interest.
- **For health care operations:** Your therapist may use information in your health record to assess the performance of operations of our services (e.g. sending a satisfaction follow up survey). This information will then be used in an effort to continually improve the quality and effectiveness of the mental health care and services we provide.
- **Provision of care and Supervision:** If your provider is a Registered Clinical Social Work, Marriage and Family Therapy, or Mental Health Counseling Intern, or Board Certified Assistant Behavior Analyst, your information may be discussed during supervision for the purpose of providing the most effective treatment, with every effort to maintain confidentiality of identifying information. Minimally necessary information may also be disclosed to the Monarch Wellness treatment team with the same purpose to provide the most effective care.
- **Research:** We may disclose health information to researchers when necessary for purposes of evaluating our programs or learning more about the problems our clients face. Established protocols will be followed to ensure the privacy of your health information.

II. Monarch Wellness. will use your PHI, *without your consent or authorization,* in the following circumstances:

- **Child Abuse or Neglect:** If we have reasonable cause to suspect that a child seen in the course of professional duties has been abused or neglected, or have reason to believe that a child seen in the course of professional duties has been threatened with abuse or neglect, and that abuse or neglect of the child will occur, we must report this to the relevant county department, child welfare agency, police, or sheriff's department.
- **Adult and Domestic Abuse:** If we believe that an elder or disabled person is the victim of abuse, neglect, or domestic violence or the possible victim of other crimes, we may report such information to the relevant county department or state official.
- **Serious Threat to Health or Safety:** If we have reason to believe, exercising best judgment and our professional care and skill, that you may cause harm to yourself or another person, we may take steps, without your consent to notify the relevant police or sheriff's department to ensure safety.
- **To your parents, if you are a minor:** Some state laws concerning minors permit or require disclosure of protected health information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the laws of Florida and will make disclosures consistent with such laws.
- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about your counseling treatment and the records thereof, such information is privileged under state law and we will not release the information without written authorization from you or your personal or legally-appointed representative, or a subpoena/court order. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court ordered.
- **As required by law for national security and law enforcement:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose health information required for lawful intelligence, counterintelligence, and other national security activities to authorized federal officials. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or crime investigation.
- **Law/Health Oversight:** As required by law, we may disclose your health information to governmental and/or licensing agencies. For example, if the Florida Department of Regulation and Licensing requests that we release records to them in order for the Examining Board to investigate a complaint against a provider, we must comply with such a request.
- **Marketing:** We may contact you to provide appointment reminders or information about counseling alternatives or other health-related benefits and services that may be of interest to you. We may also contact you to provide information about Monarch Wellness sponsored activities and events. We would only use contact information, such as your name, address, and phone number.
- **Worker's Compensation:** We may disclose health information to the extent authorized by you and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law; we may be required to testify.
- **As required by law for purposes of public health:** We may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, disability, as required by law.

For more information or to report a problem

- If you would like to make a request to amend or restrict the use or disclosure of your health information, or if you have questions or would like additional information, contact your therapist.
- If you are concerned that your privacy rights have been violated or if you disagree with a decision we have made about access to your health information, present your concerns in writing to the attention of your therapist and/or the owner and a meeting will be arranged to resolve the matter. If you have continued concerns or the matter is unresolved, you may file a complaint with the Florida Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, through the Department of Health, or the Behavior Analyst Certification Board. Monarch Wellness respects your right to the privacy of your health information. You will not be penalized for filing a complaint.

Revised 09/21/2020

FINANCIAL RESPONSIBILITY POLICY

It is a pleasure to provide you with the best possible services to help you achieve your therapeutic goals. Included in that effort, we clearly specify each client's financial responsibility to avoid any billing confusion. In order to set realistic treatment goals, it is important to evaluate how your treatment is prioritized and what resources you have available to pay for your treatment.

FEES

When your appointment is scheduled, our front desk staff will inform you of your therapist's self-pay fee at this time. **Please write in here before your first appointment so that you are fully aware**: $_____ per therapy hour (typically 45 minutes). Please note that in addition to weekly sessions, missed appointments, or cancellations within 48 hours, we charge this amount if sessions extend beyond a therapy hour (including EMDR sessions) and for other professional services you may need, at a prorated cost if we work for periods of less than one hour. Other services include telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation/writing of records or treatment summaries, and the time spent performing any other service you may request of me as your practitioner. This fee is also charged if there is a balance due to insurance not paying. We realize that our fees involve a substantial amount of money, although they are well in line with and even below similar professionals' charges. For you to get the best value for your money, we must work hard and well together.

CANCELLATION AND NO SHOW POLICY

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide at least 48 hours' advance notice of cancellation or reschedule request (unless we both agree that you were unable to attend due to illness or an emergency that is not a repeated occurrence). We are a busy practice with frequent wait lists, so please provide as much notice as possible if you need to cancel or reschedule, to allow for the space to be offered to someone else in need. We will provide the same courtesy to give you as much notice as possible if your therapist is unable to make the appointment for any reason. If you have 3 no shows or cancellations, it is at the practitioner's discretion to discontinue treatment.

LATE SHOW POLICY

Please call the office to let us know if you are running late for an appointment. If you are 15 minutes late or more, the appointment will be cancelled and you will be responsible for the cancellation/no show fee (unless you have called to let us know you are running late due to circumstances we both agree are outside of your control).

APPOINTMENT REMINDERS

Although we offer text reminders for appointments as a courtesy, it is ultimately your responsibility for maintaining your appointments. We cannot be held responsible if a courtesy text reminder is not received or if our system does not accommodate your wireless provider. If you change wireless providers, it is your responsibility to let the office know so that our system can be updated; otherwise, text reminders will not be received.

INITIALS OF CLIENT (OR GUARDIANS IF A MINOR) _____ _____

(239) 231-3208 – www.MonarchWellness.net

INSURANCE

If you have a health insurance policy, it may provide some coverage for mental health treatment. Our therapists are not contracted with insurance companies at this time. If you are interested in insurance coverage, we recommend you contact your insurance company and ask about your out of network benefits. We can provide a billing receipt upon request which you can submit to your insurance companies if you have out of network benefits.

As an ethically-guided practice, we inform our clients that any insurance involvement (in or out of network) requires us to assign a mental health diagnosis code which becomes part of your permanent medical record. This may or may not impact you in the future if an insurance company chooses to charge a higher premium for previous medical care, including mental health services. In addition, your diagnosis may be taken into consideration and records requested if you (or your child if he or she is the client) choose to pursue a career in certain government related jobs. Further, insurance companies may request additional clinical information such as treatment plans, summaries, or your entire mental health record for payment purposes, and they also often limit the number of sessions that will be covered, or require pre-authorization for more visits.

VICTIM'S COMPENSATION

If you are seeking counseling for issues related to a crime you experienced as a victim, we can assist you with verifying eligibility and applying for Victim's Compensation as payment for treatment. There are time restrictions related to applying and a police report is required with the application process.

PAYMENT METHOD

Unless we have reached an agreement regarding payment or you have paid in advance, you will be expected to pay at the beginning of each session at the time it is held. Payment may be made in the form of cash or major credit card (Visa, MasterCard, Discover, American Express). **If you have a balance due to missing an appointment or not cancelling at least 48 hours in advance, you can call the office to make a payment over the phone. The payment must be received before another appointment will be scheduled.** Our policy is to obtain your credit card information for your convenience and to cover any unpaid balances. If your account has not been paid for more than 60 days and arrangements have not been agreed upon, we have the option of charging your credit card on file or using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, the costs will be included in the claim. In most collection situations, the only information we release regarding a client's treatment is his/her name, the nature of services provided, and the amount due.

I have read the above Policy carefully and understand and agree to my Financial Responsibilities.

PRINTED NAME OF CLIENT	**CLIENT SIGNATURE**	**DATE**
PRINTED NAME OF PARENT/GUARDIAN	**PARENT/GUARDIAN SIGNATURE**	**DATE**
PRINTED NAME OF OTHER PARENT/GUARDIAN	**OTHER PARENT/GUARDIAN SIGNATURE**	**DATE**

FOR OFFICE TO COMPLETE
CLIENT:_____
PRACTITIONER:_____
□ SELF-PAY □ INS:_____
STAFF DATE/INITIALS_____

PRE-AUTHORIZED CREDIT CARD PAYMENT FORM

Like many offices, our policy is to keep a credit card on file for the convenience of virtual payment for sessions and to cover any unpaid balance. If you have a balance due to missing an appointment, or cancelling within a 48-hour timeframe not due to emergency or illness, we will contact you first to ask if you prefer to provide another form of payment prior to charging your card. We assure you that your information is respected with the highest level of confidentiality, is not shared with any other source, and is securely protected separately from your therapy file.

I, _____ authorize Monarch Wellness® (Monarch Therapy, LLC) to keep my signature on file and charge my credit card account as indicated below for payment security.

- **Initial and ongoing therapy appointments**.
- **Missed appointments** (no shows or cancelling within 48 hours) at your therapist's full self-pay fee.

I agree to inform staff of any changes with my credit card (expiration date, number, or different card if this account reaches its limit). Monarch Staff agree to give me a courtesy call regarding any unpaid balance prior to charging my card, to only charge for the circumstances listed above, and to keep my credit card information confidential in a separate locked file. ***Please present card at initial session for verification.***

CLIENT NAME:_____

CARDHOLDER NAME:_____

CARDHOLDER BILLING ADDRESS:_____

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

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CHILD/ADOLESCENT QUESTIONNAIRE FOR PARENTS

Thank you for allowing us to travel with you and your child on your healing journey. As the expert regarding your child, your responses to the following questions will help guide our path together. We realize the questions are quite thorough, as we see the value in looking at the complete picture to adequately address your child's concerns. We are shaped by our environment, biological and psychological make-up, as well as past experiences. All is interconnected and we believe that full integration and healing occurs more gracefully once the impact of all factors is acknowledged and understood. Feel free to use the back of the form if needed for more space. As with all your counseling related information, you and your child's privacy will be protected in accordance with HIPAA standards of confidentiality, with exceptions outlined in the Monarch Wellness® Notice of Privacy Policy.

Date Completed: _____ **Child/Adolescent Name:** _____

Person Completing Form and Relationship to Child: _____

A. PRIMARY CONCERN (S):

1. Please describe in your own words your concerns for which you are seeking counseling for your child/adolescent: _____

2. How long has the current issue existed / When did it occur? _____

3. How frequently does it occur?
   ___Rarely ___Occasionally ___Weekly ___Daily ___Most of the time ___Continuously

4. Please describe your expectations of counseling. (In other words, how will things be different when counseling is successfully completed?)

5. Has anything in the past helped your child/adolescent with these issues?

6. What makes it worse? _____

A. PRIMARY CONCERN (S) CONTINUED:

7. Check any of the following issues that currently affect your child AND/OR an immediate family member:

Child		Family member/relation to child	Child		Family member/relation to child
___	Depression	_____	___	Abuse issues	_____
___	Suicidal Thinking	_____	___	Legal Problems	_____
___	Grief Issues	_____	___	Work Problems	_____
___	Anxiety / Tension	_____	___	Financial Stress	_____
___	Stress Problems	_____	___	Relationship Issues	_____
___	Anger Problems	_____	___	Marital Problems	_____
___	School Problems	_____	___	Divorce/Separation	_____
___	Social skills issues	_____	___	Blended family issues	_____
___	Medical Concerns	_____	___	Pre-marital issues	_____
___	Pain Problems	_____	___	In-law Problems	_____
___	Behavioral Problems	_____	___	Sexual Problems	_____
___	Alcohol Problems	_____	___	Parenting issues	_____
___	Drug Problems	_____	___	Other: _____	_____
___	Other: _____	_____	___	Other: _____	_____

8. Please check which **BEHAVIORS** apply to your child/adolescent:

___ Frequent Crying	___ Lying	___ Sleep Problems	___ Eating problems
___ Lack of Assertiveness	___ Stealing	___ Nightmares	___ Self-neglect
___ Lack of Energy	___ Arguing/ Irritability	___ Sexual acting out	___ Blames others
___ Overactive	___ Use of alcohol	___ Declining grades	___ Other: _____
___ Impulsivity	___ Use of drugs	___ Frequent complaints of feeling sick	
___ Anger outbursts	___ Withdrawing	___ Breaking rules/Non-compliant	
___ Aggression	___ Wets/soils bed/clothes	___ Problems with family members	___ Irresponsible
___ Uses weapon	___ Indecisiveness	___ Does not want to go to school	___ Truancy
___ Hurts animals	___ Problems with peers	___ Destroys property	___ Sets fires

9. Please check which **FEELINGS** you believe your child/adolescent may be experiencing:

___ Restless	___ Fearful	___ Depressed	___ Sad	___ Annoyed
___ Guilty	___ Bored	___ Unhappy	___ Irritable	___ Jealous
___ Energetic	___ Unreal	___ Unattractive	___ Relaxed	___ Unmotivated
___ Content	___ Panicky	___ Worthless	___ Empty	___ Other: _____
___ Confused	___ Lonely	___ Hopeful	___ Happy	___ Other: _____
___ Moody	___ Stressed	___ Angry	___ Ashamed	___ Other: _____
___ Mistrustful	___ Like a failure	___ Optimistic	___ Excited	
___ Nervous	___ Helpless	___ Inferior	___ Hopeless	

10. Please check which **PHYSICAL** symptoms apply to your child/adolescent:

___ Headaches	___ Back Pain	___ Cannot Concentrate	___ Overly Tense
___ Dizziness	___ Tiredness	___ Excessive Sweating	___ Dizziness
___ Twitches/ spasms	___ Memory Problems	___ Appetite Change	___ Other: _____
___ Stomachaches	___ Dry Mouth	___ Chest Pains	___ Other: _____
___ Racing Thoughts	___ Tremors/ shakiness	___ Fainting Spells	___ Other: _____
___ Numbness/ tingling	___ Rapid Heartbeat	___ Black Outs	

B. STRENGTHS:

What are your child's strengths? (What are some positive things about your child and his/her life?)

_____

_____

_____

_____

_____

C. EDUCATIONAL INFORMATION:

1. How would you rate your child's intellectual ability?

___ Below average ___ Average ___ Above Average ___ Superior/ gifted

2. In general what grades does your child make in school?

___ Mostly A's ___ Mostly B's and A's ___ Mostly C's ___ Many D's and F's

3. Is your child in any special classes (gifted, ESE/SED, speech, etc.) or has he/she been in the past?

___ No ___ Yes: _____

4. Has your child ever repeated a grade?

___ No ___ Yes Grade/s: _____ Reason: _____

5. How many schools has your child attended?

6. Do you, your child's other parent/guardian, or your child's teachers have concerns with your child academically, socially, or behaviorally? If yes, please explain. ___ No

___ Yes: _____

7. Please indicate your and your child's other parent/guardian's highest education. Indicate M for Mother/ F for Father/C for Caregiver of child. ___ Currently in school: _____

___ Did not graduate HS ___ GED ___ High School diploma ___ Voc/bus training ___ Some college

___ Graduated College ___ Graduate Courses ___ Master's Degree ___ Doctoral Degree

8. How would you rate your and your child's other parent/guardian's intellectual ability? Indicate M for Mother/F for Father/C for Caregiver of child.

___ Below average ___ Average ___ Above Average ___ Superior/ gifted

9. In general what grades did you and your child's other parent/guardian make in school? Indicate M for Mother/F for Father/C for Caregiver of child.

___ Mostly A's ___ Mostly B's and A's ___ Mostly C's ___ Many D's and F's

10. Did you or your child's other parent/guardian have any significant problems in school (academically, socially, or behaviorally?) ___ No ___ Yes If you answered yes please describe: _____

_____

D. ECONOMIC/EMPLOYMENT HISTORY:

1. Does your child/adolescent work? ___ No ___ Yes If yes, where and how many hours/wk?

_____

2. What is your family's primary source of income?

___ Mother's earnings ___ Father's earnings ___ Both of our earnings ___ Relatives support us

___ Disability ___ Child Support ___ Government assistance ___ Other: _____

D. ECONOMIC/EMPLOYMENT HISTORY continued:

3. Are you presently employed? Indicate M for Mother/F for Father/C for Caregiver of child.
___ Yes, part time ___ Yes, full time ___ Yes, hold more than one job ___ No

4. What type of work do you and your child's other parent/guardian do?
Mother _____
Father _____
Caregiver/Guardian(s) _____

5. How long have you and your child's other parent/guardian been working at your current primary job?
M for Mother/F for Father/C for Caregiver _____
_____

6. In general, how much do you enjoy your work? Indicate M for Mother/F for Father/C for Caregiver.
___ Does not apply ___ It's enjoyable ___ It's a job ___ I don't enjoy it

7. Do you or your chid's other parent/guardian currently have, or have you had in the past, any significant problems at work? ___ No ___ Yes Describe: _____

E. MILITARY HISTORY

1. Have you or your child's other parent/guardian ever served in the military? ___ Yes ___ No (skip to section F)

2. Did you or your child's other parent/guardian ever serve in combat? ___ No ___ Yes-how long? _____

3. What kind of Discharge did you or your child's other parent/guardian receive?
___ Does not apply ___ General ___ Medical- physical ___ Dishonorable
___ Honorable ___ Administrative ___ Medical- psychiatric

F. PHYSICAL AND MENTAL HEALTH:

1. How would you describe your child? _____
_____
_____

2. Does your child currently have a pediatrician? ___ No ___ Yes
Physician's Name: _____ Telephone Number: _____

3. How would you rate your child's current level of health?
___ Excellent ___ Good ___ Fair ___ Poor ___ Very Poor

4. When was your child's last physical exam? _____

5. What was the outcome? _____

6. How would you rate you and your child's other parent/guardian's current level of health?
(Please indicate M for Mother/F for Father/C for Caregiver of child)
___ Excellent ___ Good ___ Fair ___ Poor ___ Very Poor

7. Is your child or an immediate family member currently being seen by a psychiatrist? ___ No ___ Yes, child
___ Yes, family rltn to child: _____ Psychiatrist's Name: _____ Ph#: _____

8. Is your child or an immediate family member currently being seen by another counselor/therapist?
___ No ___ Yes, child ___ Yes, family rltn to child: _____ (circle) Indiv/Marital/Family/Substance Use
Counselor's Name: _____ Phone Number: _____

9. Have you, your child's other parent/guardian, or your child received counseling/assessment in the PAST?
___ No ___ Yes If yes, complete the following: Which family member? _____

F. PHYSICAL AND MENTAL HEALTH continued:

What type of counseling? (circle) Individual / Marital / Family / Substance Abuse/ Other
When: _____ Inpatient or Outpatient (circle one)
Name of Provider/Facility: _____ Issue Addressed: _____

Other? (circle) Individual / Marital / Family / Substance Abuse/ Other
When: _____ Inpatient or Outpatient (circle one)
Name of Provider/Facility: _____ Issue Addressed: _____

10. What medications are CURRENTLY prescribed for your child's physical and mental health?

Medications	Taken for	Date Begun	Dosage Frequency	Take as Prescribed? (Y/N)	Prescribing Physician

11. Please list any psychiatric medication your child was prescribed in the PAST.

Medications	Taken for	Date Begun	Dosage Frequency	Take as Prescribed? (Y/N)	Prescribing Physician

12. Have there been any health problems/disabilities/injuries/hospitalizations (current, recent, or past)?
___ No ___ Yes _____

G. SAFETY RISK INFORMATION:

1. Has your child or any close family members ever been suicidal or experienced a mental illness?
___ No ___ Child's mother ___ Child's grandparent ___ Child's stepparent
___ Child ___ Child's father ___ Child's sibling ___ Other: _____

2. Has your child, you, or your child's other parent/guardian, or anyone else in the home had any recent thoughts about harming or killing him/herself? ___ No ___ Yes

3. Has your child, you, your child's other parent/guardian, or anyone else in the home ever attempted suicide? ___ No ___ Yes If yes, who and when? _____

4. Has your child, you, your child's other parent/guardian, or anyone else in the home had any recent thoughts about, or have recently harmed anyone else? ___ No ___ Yes

H. FAMILY/RELATIONSHIP/DEVELOPMENTAL INFORMATION:

1. Please indicate who lives in the home with your child (including yourself if applicable):
Adults: _____
Children: _____
Pets: _____

2. Are there any visitation/shared parenting arrangements? _____

3. How many homes has your child lived in? _____

4. How many caretakers has your child lived with? _____

5. Who primarily raised your child? _____

6. Who raised your child in his/her first three years of life? _____

7. Did you (or your child's birth parents if different) experience separation/divorce?
___ No ___ Yes If yes, how old was your child? _____

H. FAMILY/RELATIONSHIP/DEVELOPMENTAL INFORMATION continued:

8. How many brothers and sisters does your child have?

_____ Brothers: Names/Ages _____
_____ Step- or half brothers: _____
_____ Sisters: Names/Ages _____
_____ Step- or half sisters: _____

9. What was your child's order in birth? ___ Only child ___ Youngest ___ Middle ___ Oldest

10. How would you describe your child's relationship with

Mother: _____ Siblings: _____
Father: _____
Step-mother: _____ Step-father: _____
Grandparents: _____ Other guardian: _____
Other significant family members: _____

11. Were there any physical/mental/environmental issues during your pregnancy or the birth mother's pregnancy with your child? ___ Do not know ___ No ___ Yes: _____

12. Are you aware of any complications related to your child's birth? ___ Cesarean section
___ Born earlier than due date. How early? _____ ___ Born late. How late? _____
___ Medical concerns related to child ___ Medical concerns related to mother
___ Normal ___ Do not know ___ Other: _____

13. What age did your child reach the following developmental milestones or were there any difficulties?

	Do not know	Age	Difficulties?
Gross Motor Skills (Eg.Crawling/walking)	_____	_____	_____
Potty training	_____	_____	_____
Fine Motor Skills (Eg.Holding utensil/drawing)	_____	_____	_____
Language & Cognitive Development	_____	_____	_____
Social (Interacting with others)	_____	_____	_____

14. How would you describe your child's environment? _____

_____

_____

15. How would you describe your style of discipline? M for Mother/F for Father/C for Caretaker of child

___ Fair ___ Lenient ___ Fairly Strict ___ Strict
___ Inconsistent ___ Does not discipline ___ Other: ___ Other:

16. How is your child disciplined? _____

_____

_____

17. Are you currently having difficulty managing your child(ren's) behavior?

___ Does not apply ___ No ___ Yes, somewhat ___ Yes, a major problem

H. FAMILY/RELATIONSHIP/DEVELOPMENTAL INFORMATION continued:

18. Check the answer that best reflects your current relationship status; answer the other questions on that line as indicated. ___ Never married and not currently in a serious relationship.

	How long?	Child's bio father?
___ Currently married and living with my spouse.	_____	___ Yes ___ No
___ Not married but living with my partner.	_____	___ Yes ___ No
___ Not married but in a serious relationship.	_____	___ Yes ___ No
___ Currently separated from my spouse.	_____	___ Yes ___ No
___ Currently divorced & single.	_____	___ Yes No
___ Currently widowed When did spouse die? _____ Length of Marriage: _____		___ Yes ___ No

19. How would you describe your partner? ___ Does not apply

_____

20. How would you describe the relationship between you and your current partner? ___ Does not apply

_____

21. How do you feel your partner fulfills his/her role with you?
___ Does not apply ___ Very well ___ Fairly well ___ Poorly ___ Very poorly

22. How often, on average, do you and your partner argue?
___ Does not apply ___ Never ___ Rarely ___ Once a month
___ Once a week ___ Several times a wk ___ Daily ___ Several times a day

23. What do you and your partner argue about? (check all that apply)
___ Does not apply ___ Discipline of children ___ Relatives interfering ___ Drinking/ drug abuse
___ Money ___ Jealousy ___ Not being a good provider ___ Never argue
___ Sex ___ Religion ___ Not taking care of home ___ Other _____

I. PARENT HISTORY INFORMATION:

1. How would you describe yourself and your child's other parent/guardian as children? (Please indicate M for Mother/F for Father/C for Caregiver of child on the lines below, if known.)

_____

_____

2. How would you describe your environment/s as children? M for Mother/F for Father/C for Caregiver

_____

_____

3. What were problems for you and your child's other parent/guardian as children? Indicate all that apply with M for Mother/F for Father/C for Caregiver.

_____ Had no problems	_____ Unattractiveness	_____ Oversensitive	___ Other _____
_____ Academic	_____ Insecure	_____ Nerves	___ Other _____
_____ Was a burden	_____ Nightmares	_____ Overweight	___ Other _____
_____ Underweight	_____ Socially inept	_____ Physical/ med problems	
_____ Frequent Crying	_____ Lying	_____ Sleep Problems	___ Other _____
_____ Hyperactive	_____ Withdrawing	_____ Eating Problems	___ Other _____
_____ Unassertiveness	_____ Arguing/ Irritability	_____ Sexual acting out	___ Other _____
_____ Lack of Energy	_____ Use of alcohol	_____ Declining grades	
_____ Impulsivity	_____ Use of drugs	_____ Did not want to go to school	
_____ Anger outbursts	_____ Stealing	_____ Breaking rules/Non-compliant	

I. PARENT HISTORY INFORMATION continued:

Indicate all that apply with M for Mother/F for Father/C for Caregiver.

_____ Aggression _____ Wet/soiled bed/clothes _____ Frequent complaints of feeling sick
_____ Irresponsibility _____ Indecisiveness _____ Problems with family members
_____ Self-neglect _____ Problems with peers

J. SOCIAL SUPPORT/SELF-CARE INFORMATION:

1. How would you describe your child's current social interaction/support?
___ A lot of close friends ___ Some close friends ___ A few close friends ___ No close friends

2. How did he/she meet his/her friends? (check all that apply) Does not apply
___ Neighborhood ___ Children of parent's/caregiver's friends Work _____
___ School ___ Internet ___ Activities/Hobbies: _____ Other _____

3. What activities does your child enjoy? Alone: _____ School: _____
After-school: _____ With friends/family: _____

4. What other family members/other individuals significantly impact your child?
_____

5. How many hours a day does your child watch TV? _____ Favorite shows: _____

6. How many hours a day does your child spend on other electronics? _____
Favorites games or programs? _____

7. How often does your child and family exercise? _____

8. What type of exercise, if any, does your child and famly enjoy? _____

9. How would you describe your child and family's eating habits? _____

10. Any feelings or need for your child to lose or gain weight? ___ No ___ Yes: _____

11. Where does your child sleep? _____

12. What is your child's bedtime? Weeknights: Weekends:
Is this enforced? ___ Most of the time ___ Sometimes ___ Hardly ever ___ Only at ___ Mom's ___ Dad's

13. Does your child have difficulty ___ Falling asleep ___ Staying asleep ___ Sleeping by him/herself
___ Waking up ___ Wakes up early ___ Nightmares ___ Bedwetting ___ Other: _____

K. SPIRITUALITY/RELIGION INFORMATION

1. How would you describe the impact that spirituality/religion has on your family?
___ No influence whatever ___ Minimal influence ___ Moderate influence ___ Central part of life

2. What religion/spiritual faith do you identify with, if any? _____

3. How would you describe the impact that spirituality/religion had within your and your child's other parent/guardian's family of origin? M for Mother/F for Father/C for Caregiver
___ No influence whatever ___ Minimal influence ___ Moderate influence ___ Central part of life

4. What religion/spiritual faith did your and your child's other parent/guardian's family of origin identify with during your childhood/adolescence? M for Mothe/F for Father/C for Caregiver
_____

L. STRESSOR/TRAUMA INFORMATION

1. Which of the following has your child or family experienced in the last two years?(check all that apply)

___ Divorce	___ Change in financial state	___ Personal Illness/Injury
___ Marital separation	___ Business readjustments	___ More or less arguments with partner
___ Marital reconciliation	___ Fired at work	___ Gain of a new family member
___ Marriage	___ Retirement	___ Change in health of family member
___ Death of spouse/partner	___ Changed line of work	___ Pregnancy
___ Death of close family member	___ Moved/Relocated	___ Legal issues
___ Death of close friend	___ Sexual problems	___ Other _____

2. Has your child, you, your child's other parent/guardian, or anyone else in the family been sexually abused? ___ Unsure ___ No ___ Yes Who/when? _____

3. Has your child if applicable, you, your child's other parent/guardian, or anyone else in the family ever been sexually assaulted/raped as an adolescent/adult? ___ Unsure ___ No
___ Yes Who/when? _____

4. Has your child, you, your child's other parent/guardian, or anyone else in the family ever experienced physical or emotional abuse or neglect or has your child witnessed violence/abuse? ___ Unsure ___ No
___ Yes Who/when? _____

5. Has the Department of Children and Families ever been involved with your family? ___ Unsure ___ No
___ Yes. Please explain: _____

M. ALCOHOL/DRUG HISTORY

1. Which of the following substances has your child/adolescent, you, or your child's other parent/guardian used within the last six months, AND, of those substances, which are the the preferred substance(s) **currently**. (M for Mother/F for Father/C for Caregiver/CH for Child/Adolescent)

Six Months	Preferred		Six Months	Preferred	
_____	_____	Tobacco Products	_____	_____	Inhalants
_____	_____	Beer	_____	_____	Crack
_____	_____	Wine	_____	_____	Cocaine
_____	_____	Mixed Drinks	_____	_____	Heroin
_____	_____	Hard Liquor	_____	_____	Opiate
_____	_____	Marijuana	_____	_____	Tranquilizers- unprescribed
_____	_____	Ecstasy	_____	_____	Pain meds- unprescribed
_____	_____	Hallucinogens	_____	_____	Barbiturates
_____	_____	Amphetamines	_____	_____	None
_____	_____	List other UNPRESCRIBED meds:	_____		

2. For the **preferred** substance(s) checked above, how much is consumed each week on average? _____

3. Do you feel that your child/adolescent's, your, your child's other parent/guardian's, or anyone else in the home's use of alcohol or drugs causes a problem for the family? ___ No ___ Yes
If yes, whose use and why? _____

4. Does anyone close to you or your family (e.g., other family member, co-worker, friend) feel that use of alcohol or drugs is a problem for your family? ___ No ___ Yes

5. In your opinion, has anyone close ever had a problem with alcohol/other substances?

___ No	___ Current Partner	___ Biological grandparent	___ Child(ren)
___ Mother	___ Past Partner	___ Stepparent	___ Other: _____
___ Father	___ Sibling(s)	___ Stepsibling	

N. LEGAL HISTORY

Has your child, you, your child's other parent/guardian, or anyone in the home ever had legal problems?
(check all that apply with M for Mother/F for Father/C for Caregiver/CH for Child/Adolescent)

___ No ___ Arrested ___ Conviction with jail time
___ Civil (e.g., being sued) ___ Conviction with probation ___ Conviction with prison time
If yes, please describe: _____

ADDITIONAL INFORMATION:

Is there any other information not included above that you feel we should know about?

Thank you for taking the time to answer these questions. We hope to help your family along your wellness journey towards peaceful resolution and achievement of your child's goals.