

DSM1 _____ (Office Use)

DSM1 _____ (Office Use)

SUMMIT CENTER FOR MENTAL HEALTH Child & Adolescent Form (ages 1-17)

CLIENT INFORMATION:

Today's Date: _____ Summit Clinician: _____

First Name: _____ Middle: _____ Last: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Ok to Leave message? (circle one) Yes No

Cell Phone: _____ Ok to Leave message? (circle one) Yes No

Social Security Number: _____ Sex: _____ Birth date: _____

Email Address _____ Ok to email sensitive info? Yes No

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____

Policy ID#: _____ Group #: _____

Phone: _____ Employer Name: _____

Insured's Name: _____

Social Security Number: _____ Birthdate: _____

Address: _____ City, State, Zip: _____

Patient's Relationship to the Insured: Self _____ Spouse _____ Child _____ Other _____

AUTHORIZATION

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government/insurance benefits to myself or to *The Summit Center for Mental Health*.

Signed: _____ Date: _____

I authorize payment of medical benefits to *The Summit Center for Mental Health* for services provided.

Signed: _____ Date: _____

GUARANTOR / RESPONSIBLE PARTY INFORMATION

If the guarantor is different than the patient, please complete and sign:

Guarantor Name: _____ DOB: _____

Address: _____ City/State/Zip _____

Home Phone _____ Cell Phone _____

Soc Sec # _____ Relationship to Patient _____

E-mail Address _____

As the responsible party, I understand that I am responsible for payment of any outstanding charges on this account.

Signature _____ Date _____

Summit Center Psychiatric Child/Adolescent Intake Form

Name _____ Date _____ Date of Birth _____

A. OFFICE POLICIES

Confidentiality

- Information in my sessions is confidential EXCEPT if I am threatening to hurt myself or someone else, or if I tell of a child or an elderly person being abused. In any of these cases, the clinician will have to act upon this information to protect me or someone else.

Appointments

- _____ Initial
- There is a 24 hour cancellation fee. When I schedule an appointment, the clinician reserves that time for me and **if I cannot attend a session, I must give 24 hours notice or I will be charged for this session.**
 - The initial visit is considered to be an evaluation only and not a guarantee that treatment will be the result of said visit. This includes the prescribing of medication.
 - If I am scheduled for a medication management appointment with a psychiatrist, I understand that I am require to be on time. If I am late, I understand that I **will be required to reschedule the appointment.**

Medication Refills:

- All requests for prescription refills must be made at least **3 (three)** business days before I run out of medication. The psychiatrist may require me to be seen before refilling a prescription

Payments and Billing:

- _____ Initial
- Payment at the time of service is expected unless other arrangements have been made. If health insurance covers my sessions, The Summit Center for Mental Health will help me seek reimbursement from the insurance company. **ANY unpaid balance after insurance is MY responsibility to pay.**
 - I agree that The Summit Center for Mental Health may release to my insurance company any information needed to secure payment for services.
 - If I do not pay my account then it may be turned over to a collection agency.
 - In the event that any check I write is returned NSF (insufficient funds) I agree to pay a **\$15 service fee.**
 - **The parent accompanying the child to session is responsible for any payment unless other arrangements have been made through the billing department.**

Signature of Patient/Client Date

Signature or Parent, Guardian or Personal Representative * Date

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Patient/Client Refuses to Acknowledge Receipt:

Signature of Staff Member Date

Summit Center Psychiatric Child/Adolescent Intake Form

Name _____ Date _____ Date of Birth _____

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN (PCP)

Communication between your Summit Center clinician and your PCP can be important to help ensure that you receive comprehensive and quality health care. This information may include diagnoses, treatment plans, progress and medication. You may revoke this consent at any time, except to the extent that action has been taking in reliance upon it and that in any event this consent shall expire in one (1) year from the date of signature, unless another date is specified.

I, _____
Patient/Client (PRINT) Date of Birth Social Security Number

Please check one

- I agree to release mental health/substance abuse information to my PCP.
- I do NOT give my consent to release any information to my PCP.

Physician's Name: _____

Physician's Address: _____

Physician's Phone: _____ Fax: _____

Signature of Patient/Client Date

Signature of Parent, Guardian or Personal Representative Date

Relationship/Authority

Information for PCP:

The above named was seen on _____ for _____ by _____
Date Diagnosis/Diagnoses Clinician

Medications prescribed were:

Summit Center Psychiatric Child/Adolescent Intake Form

Name _____ Date _____ Date of Birth _____

Guardian Name: _____ Relationship to Client: _____

In your own words, tell us why you are seeking care through Summit: _____

What kind of treatment are you seeking? Therapy Medication Both Undecided

What is/are your goal(s) for seeking care through Summit? _____

What have you tried that has helped your child? _____

Are the custodial parents divorced? **Y N**

If Yes, are both parents aware of the child participating in therapy? **Y N**

If not, please explain: _____

Summit Center Psychiatric Child/Adolescent Intake Form

Name _____ Date _____ Date of Birth _____

Child Intake Symptom Check List:

- Financial difficulties Legal problems Depression Anxiety Problems sleeping Perfectionism
- Voices in my head Suicidal thoughts Suicide attempts Crying spells Hyperactivity Picky eater
- Difficulty with relationships Loneliness Anger Loss of appetite Trauma or abuse Sibling rivalry
- Weight gain Weight loss Eating disorder Self-injury Mood swings Nightmares Sexting
- Memory loss Agitation Poor concentration History of delayed development Fire-starting Gambling
- Thoughts of hurting myself Thoughts of hurting someone else Hallucinations Accident-prone Bullying
- Difficulties at school Problems using or understanding nonverbal communication Viewing Pornography
- Difficulty with social interactions or situations Poor impulse control Poor grades Cruelty to people or animals
- School refusal or truancy Vandalism or stealing Problems separating from parents/family Victim of bullying
- Other symptom(s): _____

Mental Health History:

If your child has received mental health treatment/hospitalization in the past, please tell us:

- Provider: _____ When Seen: _____ Helpful? Y N
- Provider: _____ When Seen: _____ Helpful? Y N
- Provider: _____ When Seen: _____ Helpful? Y N
- Provider: _____ When Seen: _____ Helpful? Y N

Please list any mental health diagnoses given to your child in the past: _____

Please list any mental health medications that your child has taken in the **past**: _____

Please list all of your child's **current** medications (including herbs and over the counter medicines): _____

Summit Center Psychiatric Child/Adolescent Intake Form

Name _____ Date _____ Date of Birth _____

Medical History:

Primary Care Physician: _____ Date of last exam: _____

Medication Allergies: _____

Food/Environmental Allergies: _____

Please list any conditions that your child has been diagnosed with or takes medication for: _____

Medical History Check List:

- Hospitalizations Surgeries Prematurity Asthma Head trauma Seizures Fainting
- Heart murmurs Heart palpitations Head trauma Birth control pill or injection
- Use of tobacco, alcohol, recreational drugs, or pills (including one time use)
- Sexual activity in the past 3 years
- Other: _____

Birth and Development:

Were there complications during the pregnancy? Y N

If so, what happened? _____

Was there tobacco, alcohol, drug, or toxin exposure during the pregnancy? Y N

If so, what exposure occurred? _____

Were there any complications during the delivery? Y N

If so, what happened? _____

Birth Weight: _____ Full term Premature (____ weeks early) Other: _____

Did you child leave the hospital within 2-3 days of birth? Y N

If not, why was there a delay? _____

Please tell us when your child:

Spoke his/her first word(s): _____

Began using 2-3 word phrases: _____

Began sitting unassisted: _____

Began walking: _____

Completed toilet training: _____

Summit Center Psychiatric Child/Adolescent Intake Form

Name _____ Date _____ Date of Birth _____

Has your child ever regressed or unexpectedly lost developmental milestones? Y N

If so, what skills were affected? _____

Does your child have any current problems with wetting or soiling him/herself? Y N

If so, please explain. _____

Social History:

Child's Father: Living? Y N Date of Death: _____ Cause: _____

Age: _____ Occupation: _____ Education: _____

Relationship with child is: Great Good Okay Fair Poor

Child's Mother: Living? Y N Date of Death: _____ Cause: _____

Age: _____ Occupation: _____ Education: _____

Relationship with child is: Great Good Okay Fair Poor

Child's Parents Status:

Never Married Married Separated since _____ (year) Divorced since _____ (year)

Child's Siblings: (If additional room is needed for siblings, please use the back of this page.)

Name: _____ Age: _____ Gender: M F

Relationship with child is: Great Good Okay Fair Poor

Name: _____ Age: _____ Gender: M F

Relationship with child is: Great Good Okay Fair Poor

Name: _____ Age: _____ Gender: M F

Relationship with child is: Great Good Okay Fair Poor

Name: _____ Age: _____ Gender: M F

Relationship with child is: Great Good Okay Fair Poor

Name: _____ Age: _____ Gender: M F

Relationship with child is: Great Good Okay Fair Poor

Please tell us who lives in the home with your child: _____

Family Religion/Belief System: _____

Summit Center Psychiatric Child/Adolescent Intake Form

Name _____ Date _____ Date of Birth _____

Name of Child's School: _____ Grade Level: _____

Does your child receive any of the following services?

- IEP
- Special education
- Speech therapy
- Physical therapy
- Occupational therapy

Does the school system/teachers report any concerns? If so, please explain. _____

Family History:

Is there any family history of:

- ADHD
- Bipolar disorder
- Anxiety
- Depression
- OCD
- Heart problems
- Schizophrenia/Psychosis
- Autism/Asperger's/PDD
- Cognitive/Learning Disabilities
- Legal problems or incarceration
- Alcoholism
- Drug abuse
- Gambling
- Seizures
- Mental health hospitalizations
- Emotional abuse
- Suicide attempts
- Suicide completion
- Physical abuse
- Sexual abuse
- Domestic Violence

Please list any other mental or medical illnesses that occur in the family: _____

Is there anything else that you would like your child's provider to know? _____

Summit Center Psychiatric Child/Adolescent Intake Form

Name _____ Date _____ Date of Birth _____

Adolescent Alcohol and Substance Abuse Screening:

If your child is not using alcohol or drugs, please just check here: Not-Applicable

For each of the following questions indicate "Yes" or "No"

		Yes	No
1	Do you feel you are a normal drinker ("normal"- drink as much or less than most people)		
2	Have you ever awakened in the morning after drinking the night before and found you couldn't remember a part of the evening?		
3	Does any near relative or close friend ever worry or complain about your drinking?		
4	Can you stop drinking without difficulty after one or two drinks?		
5	Do you ever feel guilty about your drinking?		
6	Have you ever attended an Alcoholics Anonymous (AA) meeting?		
7	Have you ever gotten into physical fights when drinking?		
8	Has drinking ever caused problems between you and a near relative or close friend?		
9	Has any family member or close friend gone to anyone for help about your drinking?		
10	Have you ever lost friends because of your drinking?		
11	Have you ever gotten into trouble at work because of your drinking?		
12	Have you ever lost a job because of drinking?		
13	Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?		
14	Do you drink before noon fairly often?		
15	Have you ever been told you have liver trouble such as cirrhosis?		
16	After heavy drinking have you ever had delirium tremens (DTs), severe shaking, visual or auditory (hearing) hallucinations?		
17	Have you ever gone to anyone for help with your drinking?		
18	Have you ever been hospitalized because of drinking?		
19	Has your drinking ever resulted in your being hospitalized on a psychiatric ward?		
20	Have you ever gone to any doctor, social worker, clergy, or mental health clinic for help with any emotional problems in which drinking was a part of the problem?		
21	Have you ever been arrested more than once for drinking under the influence of alcohol?		
22	Have you ever been arrested, even for a few hours, because of other behavior while drinking?		

Summit Center Psychiatric Child/Adolescent Intake Form

Name _____ Date _____ Date of Birth _____

At what age did you have your first drink? _____ At what age did you first try a drug? _____

Please complete the following for each drug you have used: if not applicable, please skip this page.

	Age of 1 st Use	When was Your Last Use	Type of Use (eg, heavy, recreational)
Alcohol			
Cocaine			
Methamphetamine			
Other Amphetamines (eg, Ritalin)			
Bath Salts			
Hallucinogens (eg, LSD, Mushrooms, PCP, salvia, ketamine)			
Heroin			
Prescription Pain Pills			
Benzodiazepines (Xanax, Valium, Klonopin, etc)			
Other Prescription Medications			
Inhalants			
Cold Medicines/Robo			
Marijuana			
K2/Spice ("Synthetic Marijuana")			
MDMA (Ecstasy/Molly)			
Other Club Drugs			
Steroids (Anabolic)			
Other:			

3033 W. Jefferson St.
Suite 107
Joliet, IL 60435
Telephone: 815-773-0772
Fax: 815-773-0771



1801 North Mill Street
Suite J
Naperville, IL 60563
Telephone: 800-786-3033
Fax: 630-357-3093

Credit Card Authorization

For internal use only.

I, _____, authorize The Summit Center to keep my signature on file and to charge my credit card listed below for:

All patient balances (less than \$250) for services rendered once the claim has been processed by my insurance company. I understand that The Summit Center will contact me by telephone for all patient balances exceeding \$250 prior to charging my card.

Recurring charges for services rendered for the following family members:

Patient Name: _____	DOB: _____
Patient Name: _____	DOB: _____
Patient Name: _____	DOB: _____
Patient Name: _____	DOB: _____

Check One: Visa _____ Master Card _____ Discover _____

Billing Address: _____
City: _____ State: _____ Zip: _____

Credit Card Number: _____ Expiration Date: _____
CVV: _____ (3 numbers on the back of the card)

Cardholder Signature: _____ Date: _____
Cardholder preferred contact number: _____

I have the right to terminate this authorization at any time and agree to do so by contacting The Summit Center at (815)773-0772.