NorthLakes
COMMUNITY CLINIC

888.834.4551
nlccwi.org

Psychiatry Intake Form- Child/Adolescent

Please complete this form before your scheduled appointment time.

General Information

DATE YOU ARE FILLING OUT THIS FORM? _____

Full Legal name: _____ Date of Birth: _____
Preferred Name: _____
Pronouns: _____ Sex assigned at birth: □Male □Female
Parent/Legal Guardian Name(s): _____
Legal shared parenting agreement? □ Yes □ No Custody concerns? □ Yes □ No

Referring Information

1. Who referred the child for Psychiatry Services_____
2. Who is your Primary Care Provider (PCP)_____
3. Who is your Therapist/Counselor _____
4. What Issues are you seeking help with: _____
5. When did these issues start: _____
6. Have you ever been told that you have a mental health or psychiatric diagnosis? □ Yes □ No
   a. If so, what _____
7. What do you hope to gain from medication management? What would be your goal?
   _____

General History

1. Current Grade: _____ Do you have a current IEP or 504 Plan at school? □ Yes □ No
2. Any behavioral or academic concerns? □ Yes □ No
3. Are you currently employed? □ Yes □ No Any extracurricular activities? □ Yes □ No
4. What do you like to do for fun? _____

Developmental History

1. Any Complications prior to or at birth? □ Yes □ No
2. Were all the developmental milestones met? □ Yes □ No
3. Any significant events or changes in life such as: □ Frequent moves □Changes in caregivers
   □ Death of a friend/relative □Witness to violence □History of abuse or neglect
   □ Other: _____

Family and Relationships

1. Who lives in your home with you? _____
2. Do you have visits with another parent? □ Yes □ No If yes, how often do you visit? _____
3. Do you have siblings who live in another home? □ Yes □ No
4. Describe your relationship with family: _____
5. Describe your relationship with friends: _____
6. Are you dating? □ Yes □ No Are you currently in a relationship? □ Yes □ No
7. Do you feel supported by your friends and family? □ Yes □ No □ Sometimes

Past Medical and Mental Health History

1. Do you have any chronic medical problems? □ Yes □ No If yes, explain: _____
   _____
2. Have you ever had a head injury, concussion, or seizure? □ Yes □ No If yes, when? _____
3. Do you currently use any drugs, alcohol, caffeine, or tobacco products? □ Yes □ No If yes, explain:
   _____
4. Does anyone in your family have any psychiatric or mental health conditions: If yes, who and what were the issues? _____
5. Have you ever seen a counselor/Therapist in the past? □ Yes □ No If yes, when and where? _____

CURRENT SYMPTOMS CHECKLIST			
Please check the appropriate box for symptoms you have experienced in the past 2 weeks.	**Daily √**	**Some √**	**None √**
Sadness/Depressed Mood			
Difficulty falling asleep			
Waking up early/during the night			
Increased need for sleep			
Feelings of guilt			
Low self-esteem			
Feelings of hopelessness			
Feelings of helplessness			
Fatigue/Low Energy			
Hard to concentrate			
Hard to make decisions			
Appetite increase or decrease			
Weight increase or decrease			
Crying spells			
Suicidal thoughts			
Attempts to harm self or "cutting"			
Isolating behaviors			
Difficulty in relationships			
Mood swings			
Increased energy			
Racing thoughts			
Increased spending			
Decreased need for sleep			
Feeling anxious			
Feeling "on edge"			
Panic Attacks			
Trembling or Shakiness			
Restlessness			
Irritability or Anger			
Shortness of Breath			
Forgetfulness			
Distractibility			
Impulsivity			
Nightmares			
Hearing or seeing things - others don't see/hear			

Name of person completing this form: _____

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Psychiatry Attendance Practices

Patient Name: _____ DOB: _____Today's Date:_____

Your regular attendance at all scheduled appointments is important in order for medication management for Psychiatric care to be effective.

REFERRALS:
Upon receiving a referral, we will call you to schedule an appointment. At least three attempts will be made to reach you by phone. If we can't reach you by phone, we will send you a letter. If we are unable to reach you within 10 days, we will close your referral and notify the referring provider.

INTAKE APPOINTMENTS:
An intake appointment is scheduled for 60-90 minutes. Intake appointments should be rescheduled or canceled at least 24 hours in advance. After two missed intake appointments we will close your referral and notify the referring provider. After two missed intake appointments we may be unable to schedule future appointments.

CANCELLATIONS – NON-EMERGENCY:
Except for emergency situations, all appointments must be canceled at least 24 hours in advance. Examples of non-emergencies include vacations, family events, school activities, schedule conflicts, and family illness.

CANCELLATIONS – EMERGENCY:
In case of an emergency, appointments must be canceled as early as possible before your appointment. Examples of emergencies include sudden onset of illness for you or a child, death in family, and hospitalization/urgent care.

CLOSINGS DUE TO WEATHER:
If NorthLakes Community Clinic must be closed due to inclement weather, we will contact you. Please note, we do not always close when schools are closed. If we are open, and you decide to cancel due to weather conditions, we ask that you notify us at least 2 hours before your scheduled appointment.

ATTENDANCE:
If two appointments are missed and/or canceled within less than 24 hours, we may not be able to schedule additional appointments for you. A third missed appointment may result in limiting scheduling to same day appointments.

CONTINUITY OF CARE:
In order to safely assess your needs and provide you with the best treatment possible, we require an in-person appointment every 6 months at a minimum. More frequent in-person appointments may be indicated. Your provider will discuss options, including virtual/telehealth visits for your regularly scheduled follow up visits. Attendance and cancellation practices noted above also apply to virtual/telehealth visits.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ, UNDERSTAND, AND AGREE WITH THE INFORMATION OUTLINED ABOVE:

X_____ _____
Patient Signature Date

X_____ _____
Parent/Guardian Signature Date

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INFORMED CONSENT- BH

Patient Name:_____ DOB:_____

I understand that I am seeking services regarding a health problem or suspected health problem at NorthLakes Community Clinic (NorthLakes) to be provided by authorized employees of the Clinic, etc. I consent to routine services, which may include but are not limited to: assessment, evaluation, diagnosis, treatment planning, therapy, group therapy, education, discharge planning, referral, and follow up care. These program elements have been explained to me and I understand what the services are. I understand I can withdraw this consent at any time, and that **it is effective for one year from this date**.

In addition to the above be informed that:

- Benefits that will come from this treatment could include a solution to your presenting problem, better coping skills or a better adjustment to your life situation.
- You and your provider will establish a treatment plan that will include how often you will meet with the provider and who may be included in your treatment.
- The clinician providing treatment may not be credentialed by OptumHealth/UBH and the visits will be billed under their supervising provider.
- Treatment does not always result in positive changes. Occasionally the problems remain despite your and your provider's best efforts. In some cases, new problems may arise, or unwanted changes occur. For example, talking about your depression may make you feel worse initially, or as you get better, other problems arise and become important.
- Besides the proposed ways of addressing your problems, there are other resources such as self-help groups, spiritual teachers, cultural activities, church or other support groups or providers with different approaches.
- If you elect not to seek treatment a number of things could happen. Your problems may solve themselves, your problems may remain as they are, your problems may worsen, or new problems may appear.
- Information shared in visits is confidential and will not be released without specific written authorization from you or your representative. For the purpose of continuity of care, information can be shared with other providers within the NorthLakes Clinic who are also involved in your treatment. This confidentiality remains after termination and we maintain records for seven years.

Information that cannot be kept confidential that your provider and NorthLakes Community Clinic is required by law to release includes:

- Suspected or actual physical and/or sexual abuse or neglect of a child or vulnerable adult
- Information requested in a court order.
- Situation in which you are judged to be in imminent or immediate danger of harming self or others.

NorthLakes Clinic does not provide emergency behavioral health care. In case of an emergency, please contact your local emergency room or call the Suicide and Crisis Lifeline at 988.
Our general hours of service are 9:00AM-5:00PM.

By my signature below, I give consent for the administration of the above described treatment. I have been given complete and accurate knowledge, and I understand that no promises have been made to me as to the results of the treatment.

X_____ _____

Signature of Patient/Legal Guardian Date

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CLIENT RIGHTS POLICY- BH

Patient Name: _____ DOB: _____

Clients have the following rights under Wisconsin state law:

- The right to be informed of your rights as a patient/client.
- Nondiscrimination on the basis of race, religion, age, sex, or sexual orientation, ethnic origin, physical or mental impairment, financial or social status.
- The right to the least restrictive treatment conditions necessary.
- The right to receive prompt and adequate treatment.
- The right to be informed of your treatment and care, treatment options and to participate in the planning of your treatment and care.
- The right to be free from any unnecessary or excessive medications at any time.
- The right to refuse all medication and treatment unless court-ordered or unless medication and/or treatment is necessary to prevent serious physical harm to yourself or to others.
- The right to a humane psychological and physical environment.
- The right not to be subjected to experimental research without your informed, written consent.
- The right not to be subjected to psychosurgery or other drastic treatment procedures without your written, informed consent.
- The right to petition the court for review of your commitment order.
- The right to confidentiality of all treatment records, to review and copy certain records, and to challenge the accuracy, completeness, timeliness or relevance of information in your records in accordance with the provisions of section.
- The right not to be filmed or taped without your permission.
- Be informed about the costs of treatment and medications.
- The right to file a grievance about violation of these rights without fear of retribution.
- The right to go to court if you believe that your rights were violated.
- Have the right to be treated with respect and recognition of the patient's dignity and individuality by all employees of the treatment facility or community mental health program and by licensed, certified, registered or permitted providers of health care with whom the patient comes in contact.

By my signature below, I acknowledge that I received or was offered a copy of the Clients Rights.

X_____ _____

Signature of Patient/Legal Guardian Date