



**PETOSKEY WELLNESS PROGRAM  
Parent/Guardian Consent for Services**

Received \_\_\_\_\_  
Initials      Date

*Please print all forms in black ink.*

<b>Child/Adolescent Name</b>		<b>Birth Date</b>	<b>Age</b>	<b>Gender</b>	<b>Grade</b>	<b>School/Teacher</b>
<b>Street Address</b>		<b>Mailing Address (PO Box)</b>	<b>City</b>	<b>Zip Code</b>	<b>Child Social Security #</b>	
<b>Race (Optional)</b> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> More Than One <input type="checkbox"/> Other						
<b>Ethnicity (Optional)</b> <input type="checkbox"/> Non-Arabic/Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Arabic						
<b>Mother/Parent Name</b>		<b>Mother/Parent Birth Date</b>	<b>Mother/Parent Social Security #</b>		<b>Phone Number</b>	
<b>Father/Parent Name</b>		<b>Father/Parent Birth Date</b>	<b>Father/Parent Social Security #</b>		<b>Phone Number</b>	
<b>Preferred Telephone Number</b>		<b>May We Leave a Message?</b> Yes      No		<b>Best Time of Day to Be Contacted?</b>		
<b>Guardian Last Name (if different than mother/father)</b>		<b>Guardian First Name</b>	<b>Guardian Telephone Number</b>	<b>Guardian Birth Date</b>	<b>Relationship To Student</b>	
<b>Name of Emergency Contact (other than parent/guardian)</b>			<b>Relationship</b>	<b>Telephone Number</b>		
<b>Name of Student's Physician or Clinic</b>		<b>Physician or Clinic Telephone Number</b>		<b>Name of Student's Dentist</b>		

<b>HEALTH INSURANCE (Please complete all information)</b>	
<input type="checkbox"/> None (uninsured) Please contact me about MI Child/Healthy Kids health insurance for my child. <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Medicaid/Medicaid HMO      Child's Card Number _____	
<input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> Blue Care Network <input type="checkbox"/> Priority Health <input type="checkbox"/> TriCare <input type="checkbox"/> Other: _____ Address and Phone Number on back of Insurance Card _____ _____ _____	Name of Policy Holder _____ Insurance Policy Number _____ Insurance Group Number _____ Birth Date of Policy Holder _____ Relationship of Policy Holder to child? _____ Does your insurance pay for immunizations? <input type="checkbox"/> Yes <input type="checkbox"/> No

1. Would you like information from our staff regarding:	
Options for health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Finding a health care provider (doctor or nurse practitioner)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Finding a dentist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you concerned about your income meeting the basic needs of your family?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Please circle your concerns:</b> Food    Clothing    Housing    Paying for bills for heat and water    Transportation to medical or school appointments	
<i>If you answered YES to any of the above, a member of our staff will contact you</i>	

## BEHAVIORAL HEALTH TREATMENT CONSENT FORM

*Alcona Health Center (AHC) is offering behavioral health services (BHS) at Petoskey High School. This is a service to students enrolled in Petoskey High School. These services will be provided by **Paula Wilson, LPC, Licensed Professional Counselor**, employed by AHC as a Behavioral Health Therapist. In order for those services to begin, a parent or legal guardian must give written, informed consent, as outlined below.*

As the parent or legal guardian of \_\_\_\_\_ (Name of child)

Parent/Guardian Signature needed here.

**Consent for Services**

1. I understand that BHS will include a behavioral health assessment of my child, during which I will be asked to provide information about my child’s emotions needs, and behavior at home and school. I will be invited to be actively involved in the treatment planning for my child. Acceptance of counseling services for my child is on a voluntary basis, and I may terminate these services at any time.
2. I understand that **Paula Wilson, LPC**, maintains professional liability coverage, and follows federal and state laws protecting client’s rights to confidentiality of personal information. I understand these laws allow the exchange of Protected Health Information with other medical personnel involved in the treatment of my child. I have the right to be informed of these exchanges of information and may request more information about HIPAA from my provider.
3. I understand it is not necessary to renew my consent yearly. I further authorize the Petoskey Wellness Program to release information regarding treatment to the following: Petoskey Wellness Program staff and its subcontractors, and other health care providers when needed to coordinate care; school staff when needed to coordinate services at school; and third-party payers when needed for payment of services. I understand I may withdraw my consent for services at any time upon written notice.
4. By signing this agreement I am aware it is my responsibility to get consent for treatment from any other adult who has legal right to be informed of treatment.
5. I understand that counseling is a fee for service agreement and that my insurance company will be billed for services, and that I will be responsible for any additional fees not covered by the insurance provider. A fee schedule is available upon request.
6. I understand that federal and state regulations protect the confidentiality of my child’s records maintained by this program, except when the following conditions exist:
  - a. There is suspected evidence of child abuse, neglect, or danger to my child; or,
  - b. My child makes a serious threat to harm themselves (suicide) or others (homicide); or,
  - c. A medical emergency requires disclosure to medical personnel; or,
  - d. My written permission is given to release this information, which may be authorized to specific agencies or persons on a separate consent form.

**I have read and understand the conditions outlined above, and by signing below allow Paula Wilson, L.P.C. to offer Behavioral Health services to my child.**

Signature of Parent(s) or Legal Guardian	Date	Signature of Witness	Date
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***Please return completed form to:***

<u>Petoskey High School</u> 1500 Hill St. Petoskey, MI 49770 (231) 412-6456	<u>Petoskey Middle School</u> 801 Northmen Dr. Petoskey, MI 49770 (231) 412-6455	<u>Central Elementary School</u> 410 State St. Petoskey, MI 49770 (231) 412-6453	<u>Lincoln Elementary School</u> 616 Connable Ave. Petoskey, MI 49770 (231) 412-6453	<u>Ottawa Elementary School</u> 871 Kalamazoo Ave. Petoskey, MI 49770 (231) 412-6454	<u>Sheridan Elementary School</u> 1415 Howard St. Petoskey, MI 49770 (231) 412-6454
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The Petoskey Wellness Center is operated by Alcona Health Center, with major funding from Petoskey Harbor Springs Foundation, Michigan Health Endowment Fund, Michigan Department of Health and Human Services and Michigan Department of Education.

Child's Name \_\_\_\_\_  
 Today's Date \_\_\_\_\_  
 Date of Birth \_\_\_\_\_

Record Number \_\_\_\_\_  
 Filled out by \_\_\_\_\_

## Pediatric Symptom Checklist

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

		Never (0)	Sometimes (1)	Often (2)
1. Complains of aches/pains	1	_____	_____	_____
2. Spends more time alone	2	_____	_____	_____
3. Tires easily, has little energy	3	_____	_____	_____
4. Fidgety, unable to sit still	4	_____	_____	_____
5. Has trouble with a teacher	5	_____	_____	_____
6. Less interested in school	6	_____	_____	_____
7. Acts as if driven by a motor	7	_____	_____	_____
8. Daydreams too much	8	_____	_____	_____
9. Distracted easily	9	_____	_____	_____
10. Is afraid of new situations	10	_____	_____	_____
11. Feels sad, unhappy	11	_____	_____	_____
12. Is irritable, angry	12	_____	_____	_____
13. Feels hopeless	13	_____	_____	_____
14. Has trouble concentrating	14	_____	_____	_____
15. Less interest in friends	15	_____	_____	_____
16. Fights with others	16	_____	_____	_____
17. Absent from school	17	_____	_____	_____
18. School grades dropping	18	_____	_____	_____
19. Is down on him or herself	19	_____	_____	_____
20. Visits doctor with doctor finding nothing wrong	20	_____	_____	_____
21. Has trouble sleeping	21	_____	_____	_____
22. Worries a lot	22	_____	_____	_____
23. Wants to be with you more than before	23	_____	_____	_____
24. Feels he or she is bad	24	_____	_____	_____
25. Takes unnecessary risks	25	_____	_____	_____
26. Gets hurt frequently	26	_____	_____	_____
27. Seems to be having less fun	27	_____	_____	_____
28. Acts younger than children his or her age	28	_____	_____	_____
29. Does not listen to rules	29	_____	_____	_____
30. Does not show feelings	30	_____	_____	_____
31. Does not understand other people's feelings	31	_____	_____	_____
32. Teases others	32	_____	_____	_____
33. Blames others for his or her troubles	33	_____	_____	_____
34. Takes things that do not belong to him or her	34	_____	_____	_____
35. Refuses to share	35	_____	_____	_____

Total score \_\_\_\_\_

Does your child have any emotional or behavioral problems for which she/he needs help? ( ) N ( ) Y

Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services? \_\_\_\_\_

# CHILD INTAKE FORM

## GENERAL INFORMATION

Welcome to Petoskey Wellness Program. Thank you for taking the time to fill out this form. The information you provide here is protected and confidential information and will be helpful for the therapist to care for your child. If you need help completing this form please bring to the first session.

Child's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

What is the main reason(s) you're seeking help for your child? (Include how long he/she's had these symptoms or problems):

\_\_\_\_\_  
\_\_\_\_\_

What are your hopes regarding your child's therapy? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## HEALTH & MENTAL HEALTH INFORMATION

Does your child currently have any medical problems? \_\_\_\_\_

\_\_\_\_\_

Has your child ever been treated for any of the following? If so please circle and describe:

Head injury or loss of consciousness, frequent ear infections, tubes placed, hearing or vision problems, headaches, meningitis, seizures, asthma, elevated lead levels, slow/fast growth, allergies, cancer, surgeries, anemia, vitamin deficiencies, any other conditions:

\_\_\_\_\_  
\_\_\_\_\_

Has your child previously seen a therapist or psychiatrist? If so, what year? Who did he/she see and for what reason? About how many meetings did your child have? Was the experience helpful or not? How so?

\_\_\_\_\_  
\_\_\_\_\_

Has your child ever been hospitalized for medical or mental illness? If so, list when, where, & reason:

\_\_\_\_\_  
\_\_\_\_\_

Please list your child's current prescription medications with dosage and current prescriber of medication

(psychiatric and general health) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does your child take medication regularly as prescribed? Yes or No

Please list any previous psychiatric medications (with dosage and dates) \_\_\_\_\_

\_\_\_\_\_

Do you suspect or know your child drinks alcohol or uses recreational drugs? If so, what kind & how often?

Do you or anyone close to your child consider his/her use to be a problem? Yes    No

When was your child's last complete physical exam (mo/year)? \_\_\_\_\_

Is sexual behavioral/sexuality/gender identity a concern for your child or family? \_\_\_\_\_

How many times a week does your child exercise? \_\_\_\_\_ What type & how many minutes? \_\_\_\_\_

What types of food does he/she often eat? \_\_\_\_\_

Sleep schedule: \_\_\_\_\_ Total hours: \_\_\_\_\_

Electronic/Technology/Screen Use \_\_\_\_\_

**YOUR CHILD'S FAMILY**

	<b>BIOLOGICAL MOTHER</b>	<b>BIOLOGICAL FATHER</b>
<b>Current age, or If deceased date, age, &amp; cause of death</b>		
<b>Country of Origin</b>		
<b>Occupation</b>		
<b>Religious/Spiritual Affiliation (if any)</b>		
<b>Highest grade completed</b>		
<b>Any history of the following (please circle)</b>	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse
<b>Describe each parent's relationship with the child</b> Give some examples of things that you do together & feelings you have		

Parents are (choose one): Married Separated Divorced Living Together

If separated or divorced, how old was your child when the separation occurred? \_\_\_\_\_

Child lives with (please list all adult household members): \_\_\_\_\_

Who has legal/physical custody? \_\_\_\_\_

Please describe the current visitation schedule (if any) and type of communication with child's other parent:

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**Siblings:** Please list your child's brothers and sisters in the order of birth (including adopted or step siblings).

First name	Biological, Adopted or Step	Current Age	School grade?	Male/ Female	Lives with you? (Yes/No)	Any medical, social or academic problems (please list for each)?

**FAMILY MENTAL HEALTH HISTORY**

In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please circle	List Family Member(s)
Anxiety (general)	Yes No	
Obsessive Compulsive Behavior	Yes No	
Depression	Yes No	
Suicide Attempts	Yes No	
Bipolar/Manic Depressive	Yes No	
Alcoholism	Yes No	
Substance Abuse	Yes No	
Domestic Violence	Yes No	
Eating Disorders	Yes No	
Obesity	Yes No	
Schizophrenia	Yes No	
Counseling or Psychotherapy	Yes No	
Psychiatric Hospitalizations	Yes No	

**YOUR CHILD'S DEVELOPMENTAL HISTORY**

**Pregnancy and Birth**

Where there any complications during pregnancy (high blood pressure, diabetes, hospitalization): If so, please describe:

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Medications used during pregnancy? Please list: \_\_\_\_\_

Smoking? Yes No How much? \_\_\_\_\_

Alcohol intake? Yes No How much? \_\_\_\_\_

Drug intake? Yes No How much? \_\_\_\_\_  
Length of pregnancy? \_\_\_\_\_ Weeks Age of mother at birth: \_\_\_\_\_ Birth weight: \_\_\_\_\_  
Were there any complications during delivery? If so, please describe: \_\_\_\_\_  
\_\_\_\_\_

Length of stay in the hospital? Mother: \_\_\_\_\_(days) Child: \_\_\_\_\_(days)

### **Developmental Milestones and Early Development**

At what age did your child do the following (indicate approximate month or year of age for each):

Turn over \_\_\_\_\_ Crawl \_\_\_\_\_ Stand Alone \_\_\_\_\_ Walk Alone \_\_\_\_\_

First Words \_\_\_\_\_ First Phrases \_\_\_\_\_

Toilet trained? Yes No If yes, days? \_\_\_\_\_ Nights? \_\_\_\_\_

Has your child wet or soiled himself after being trained? Yes No If yes, until what age? \_\_\_\_\_

Enjoyed cuddling? Yes No Fussy, Irritable? Yes No More active than other babies? Yes No

If your child has siblings, was development different in any way? Explain: \_\_\_\_\_  
\_\_\_\_\_

### **YOUR CHILD'S SCHOOL, HOME, SOCIAL & PERSONAL FUNCTIONING**

#### **School/Academics**

Your child's current grade? \_\_\_\_\_ Has he/she ever repeated a grade? Yes No If so, which? \_\_\_\_\_

Other schools attended (grades/year): \_\_\_\_\_

What preschool experience did your child have? \_\_\_\_\_

Where any problems detected in your child's kindergarten screening? Yes No If so, please explain: \_\_\_\_\_  
\_\_\_\_\_

Is your child in a regular classroom? Yes No Does your child have: an IEP? Yes No a 504? Yes No

Has your child ever received tutoring/other services (eg. Char/Em ISD) Yes No

If yes, please explain: \_\_\_\_\_

What are your child's typical grades? \_\_\_\_\_

What are your child's strongest and weakest points academically? \_\_\_\_\_  
\_\_\_\_\_

Are you satisfied with your child's educational program? Yes No Please explain: \_\_\_\_\_  
\_\_\_\_\_

#### **Home/Family Life**

What are 5 things that you enjoy most about your child? \_\_\_\_\_  
\_\_\_\_\_

What are some activities you engage in as a family? \_\_\_\_\_

Does your child participate in any religious or faith based group? \_\_\_\_\_

Does your child listen and obey instructions 75% of the time? Yes No

What are your discipline techniques? \_\_\_\_\_

What are your strengths personally and as a parent? \_\_\_\_\_

What are some of your areas of needed growth? \_\_\_\_\_

What are your child's strengths (things he/she is good at)? \_\_\_\_\_

What are your child's areas of needed growth? \_\_\_\_\_

**Social and Community Engagement**

What are your child's favorite activities or hobbies? \_\_\_\_\_

In what extracurricular/community activities is he/she involved? \_\_\_\_\_

How does your child get along with other children? \_\_\_\_\_

Who are some of your child's closest friends (first name) \_\_\_\_\_

Does your child prefer to play at your home or others' homes? \_\_\_\_\_

**Family Stressors**

How stressful would you rate your family life? (circle one)

0 (no stress)      1      2      3      4      5 (highly stressful)

Has your child experienced any recent or past stressors? Yes No  
(e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child's changes school, family moved, family financial problems, remarriage, sexual trauma, other losses)?

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Has Child Protective Services ever been involved with your family? \_\_\_\_\_

Do you have any concerns of current abuse/neglect (emotional, physical, sexual) or safety of your child?  
\_\_\_\_\_

Please use the back provide any additional information which you would like me to know or which you feel would be helpful to better understand your child.

\_\_\_\_\_  
Printed Name/Signature of Person Completing Form

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date