PETOSKEY WELLNESS PROGRAM
Minor Consent for Services

Received_____ _____
Initials Date

Please print all forms in black ink.

Child/Adolescent Name	Birth Date	Age	Gender	Grade	School/Teacher

Street Address	Mailing Address (PO Box)	City	Zip Code	Child Social Security #

Race (Optional) ❒ **White** ❒ **Black** ❒**Asian** ❒**American Indian** ❒ **More Than One** ❒ **Other**

Ethnicity (Optional) ❒ **Non-Arabic/Non-Hispanic** ❒**Hispanic** ❒**Arabic**

Mother/Parent Name	Mother/Parent Birth Date	Mother/Parent Social Security #	Phone Number

Father/Parent Name	Father/Parent Birth Date	Father/Parent Social Security #	Phone Number

Preferred Telephone Number	May We Leave a Message? Yes No	Best Time of Day to Be Contacted?

Guardian Last Name (if different than mother/father)	Guardian First Name	Guardian Telephone Number	Guardian Birth Date	Relationship To Student

Name of Emergency Contact (other than parent/guardian)	Relationship	Telephone Number

Name of Student's Physician or Clinic	Physician or Clinic Telephone Number	Name of Student's Dentist

HEALTH INSURANCE (Please complete all information)

❒ **None (uninsured) Please contact me about MI Child/Healthy Kids health insurance for my child.** ❒ **Yes** ❒ **No**

❒ **Medicaid/Medicaid HMO** **Child's Card Number** _____

❒ **Blue Cross/Blue Shield**
❒ **Blue Care Network**
❒ **Priority Health**
❒ **TriCare**
❒ **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? ❒ **Yes** ❒ **No**

1. Would you like information from our staff regarding:	
Options for health insurance?	❒Yes ❒No
Finding a health care provider (doctor or nurse practitioner)?	❒Yes ❒No
Finding a dentist?	❒Yes ❒No
2. Are you concerned about your income meeting the basic needs of your family?	❒Yes ❒No

Please circle your concerns: Food Clothing Housing Paying for bills for heat and water Transportation to medical or school appointments

If you answered YES to any of the above, a member of our staff will contact you

MINOR CONSENT

Confidential Services:

Under Michigan law, I understand that minors may without parental consent, receive advice, testing and/or treatment for substance abuse, family planning counseling services; sexually transmitted diseases, HIV, and mental health services, which are defined as Confidential Services.

I further understand that minors above the age of 14 years can, without parental consent, obtain limited outpatient mental health services not to exceed 12 visits over four months and not to include any medications. I understand that the counselor treating me may notify my parent or guardian without my permission if someone is hurting me or I am hurting myself or someone else, or if I have a plan to hurt myself or someone else, or if it is seen to be in my best interest. In those cases, the counselor will try to inform me of their duty to notify my parents before informing them.

If I am seeking information or intervention about one of the confidential services, I understand that I can seek care related to these issues at the Petoskey Wellness Program.

I have read and understand the above information and sign it freely and voluntarily.

By signing this form I agree to the following:

- **I have reviewed and understand the Confidential Services offered by the Petoskey Wellness Program. I give my consent to receive the services described above until age 18. 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, its subcontractors, and other health care providers when needed to coordinate care and school staff when needed to coordinate services. I understand I may withdraw my consent for services at any time upon written notice.**
- **I received a copy of the Alcona Health Center's *Notice of Privacy Practices* brochure.**
- **I have completed the enclosed *Student and Family Health History* form on the back side of this form.**
- **I understand there will be no charge or billing for this service.**

_____ _____

(DATE) (Printed Name and Birth Date)

_____

(Signature)

_____

(Witness Signature)

Petoskey High School
1500 Hill St.
Petoskey, MI 49770
(231) 412-6456

Petoskey Middle School
801 Northmen Dr.
Petoskey, MI 49770
(231) 412-6455

Central Elementary School
410 State St.
Petoskey, MI 49770
(231) 412-6453

Lincoln Elementary School
616 Connable Ave.
Petoskey, MI 49770
(231) 412-6453

Ottawa Elementary School
871 Kalamazoo Ave.
Petoskey, MI 49770
(231) 412-6454

Sheridan Elementary School
1415 Howard St.
Petoskey, MI 49770
(231) 412-6454

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

	BIOLOGICAL MOTHER	**BIOLOGICAL FATHER**
Current age, or If deceased date, age, & cause of death		
Country of Origin		
Occupation		
Religious/Spiritual Affiliation (if any)		
Highest grade completed		
Any history of the following (please circle)	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse
Describe each parent's relationship with the child 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:

_____

_____

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:

_____

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

Child's Name _____ Record Number _____
Today's Date _____ Filled out by _____
Date of Birth _____

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?_____