



### CHILD REGISTRATION FORM

Please complete all information on this form. If you need help, please speak to one of our Staff.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Preferred Name/Nickname: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Referred by: \_\_\_\_\_ Referral Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ Phone: Home: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_ Contact Preference: \_\_\_\_\_ Cell: \_\_\_\_\_

Primary Language: \_\_\_\_\_ Religious Preference: \_\_\_\_\_

Race:  White  Black  Asian  American Indian  Alaskan Native  Native Hawaiian  Pacific Islander  Multi-Racial

Ethnicity:  Puerto Rican  Mexican  Cuban  Other Hispanic  Haitian  Mexican American  Spanish/Latino  
(check one)  None of the Above

Marital Status:  Never Married  Married  Widowed  Divorced  Separated  Domestic Partner  Legally Separated

Employment Status:  Active Military  Full Time  FT Self-Employ  Part Time  PT Self-Employ  Unemployed  Disabled  
 Retired  Student  Homemaker  Leave of Absence  Criminal Inmate  Not Authorized to Work

Current Grade: \_\_\_\_\_ School: \_\_\_\_\_

Have you ever been known by another name or former alias:  No  Yes Name: \_\_\_\_\_

Do you have a case plan with the court system or Eckerd Community Alternatives:  Yes  No

Residential Status:  Independent Living Alone  Independent Living-with Relatives  Independent Living-with Non-Relatives  
 Dependent Living-w/Relatives  Dependent Living-w/Non-Relatives  Homeless  Group Home  Jail  
 Assisted Living Facility  Mental Health Institute  Nursing Home  Supported Housing  Foster Care  
 DJJ Facility  Crisis Residence  Children Residential Treatment  Limited MH Licensed ALF  Other

Number in Household: \_\_\_\_\_ Have you ever received services here before?  No  Yes  
Veteran:  Yes  No If so, when: \_\_\_\_\_

#### IDENTIFY DISABILITY FACTORS:

Developmental Disabilities:  Yes  No Physically Impaired:  Yes  No  
Non- Ambulatory:  Yes  No Visually Impaired:  Yes  No  
Deaf or Hard-of-Hearing:  Yes  No ADL Functioning:  Yes  No  
English Language Severely Limited:  Yes  No (Inability to perform independently day-to-day living)

What auxiliary aids, services, or assistance do you need to help you communicate with us? \_\_\_\_\_

#### PARENT / GUARDIAN

Name: \_\_\_\_\_ Phone: Home: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ Work: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Relation: \_\_\_\_\_

Legal Guardian:  Yes  No

Client Name: \_\_\_\_\_ Client #: \_\_\_\_\_

**MEDICAL BENEFITS**

Medicaid #: \_\_\_\_\_

Medicare#: \_\_\_\_\_

Do you have any other insurance? (Other than Medicaid/Medicare)  Yes  No Name: \_\_\_\_\_

I authorize the release of any medical information necessary to process this or a related claim to:	
_____	Date: ____ / ____ / ____
Insurance Company Name and Address	
I authorize payment of benefits to Directions for Living.	
_____	Date: ____ / ____ / ____
Signature	

**MEDICAL INFORMATION**

Primary Care Physician: _____	Phone #: _____
Other Treating Physician: _____	Phone #: _____
Pain Management Specialist: _____	Phone #: _____
Preferred Pharmacy: _____	Phone #: _____
Pharmacy Location: _____	

**SERVICE AUTHORIZATION / CONSENT TO TREAT / CONSENT TO PARTICIPATE**

My signature below certifies that:

- 1) I give permission to staff of Directions for Living to render mental health/substance abuse treatment and/or prevention services to the person named below.
- 2) I have received a copy of the Client Handbook which includes information regarding:
 

▪ Organizational Mission	▪ Hours of Operation
▪ Emergency Procedures	▪ Treatment Services
▪ Client Rights and Responsibilities	▪ Grievance Procedures
▪ Infectious Disease Control	▪ HIV/AIDS Education
▪ Notice of Privacy Practices	▪ Advance Directive
- 3) I have received the HIV/AIDS education information and understand that I may ask for further information regarding testing and other services at any time.
- 4) I understand that I may be contacted about my services at Directions for Living during or after services for quality improvement purposes.
- 5) I understand that Directions may be required to submit statistical and demographic information such as my age, social security number and/or income to certain local, state and/or federal agencies in order to provide my services. I also understand that I may ask for more specific information regarding this at any time.
- 6) I am providing this consent to treatment and/or prevention services voluntarily and understand that I have the right to withdraw my consent at any time.

\_\_\_\_\_  
Print Client Name

\_\_\_\_\_  
Client Signature

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

\_\_\_\_\_  
Guardian Signature (if applicable)

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

\_\_\_\_\_  
Relation to Client

\_\_\_\_\_  
Witness

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

Client Name: \_\_\_\_\_ Client #: \_\_\_\_\_

Our funders require that we collect information on everyone who lives in the household with the child who is receiving services. Please complete the following information about everyone who lives in the child's household.

Household Member	Gender	Relationship to child	Race / Ethnicity	DOB	Highest Education	Language	Citizen Y/N?	Employed Y/N?	Marital Status	For Office Use Only: Service Activity
	<input type="checkbox"/> F <input type="checkbox"/> M	Mother /Guardian					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		
SS#										
	<input type="checkbox"/> F <input type="checkbox"/> M	Father /Guardian					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		
SS#										
	<input type="checkbox"/> F <input type="checkbox"/> M	Sibling /Other					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		
SS#										
	<input type="checkbox"/> F <input type="checkbox"/> M	Sibling /Other					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		
SS#										
	<input type="checkbox"/> F <input type="checkbox"/> M	Sibling /Other					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		
SS#										
	<input type="checkbox"/> F <input type="checkbox"/> M	Sibling /Other					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		
SS#										

Client Name: \_\_\_\_\_

Client #: \_\_\_\_\_

9600-018c

Rev. 04/05/2013

# OUR COMMITMENT TO YOU + YOUR COMMITMENT TO YOUR CHILD

Welcome to the Children's Outpatient Program...we are very glad you're here and look forward to working with you and your child!

- We have found that in order to have the best results in therapy, it is important to have consistent counseling appointments.
- We understand that sometimes things happen that make it hard to come for appointments.
- We have a high demand for our services and appointment times.
- We ask that you please call us to cancel if you can't keep your appointment. It is our policy that if you repeatedly cancel your child's appointments, his or her chart may be closed.
- An appointment that is not cancelled within 24 hours will be considered a "no show."
- Two consecutive "no shows" or three total "no shows" may result in your child's case being closed.
- Once closed, in order to start services again, you would need to reapply for services and there is no guarantee the same therapist would be available to work with your child.

Keep the following tips in mind when scheduling appointments:

- Consider scheduling therapy and medical appointments on the same day if possible to minimize time missed from school
- Keep in mind, the later in the day you want appointments, the less frequently your child may be able to be seen
- Be aware of your child's school calendar and other important dates that might conflict with therapy or medical appointments, such as exams, field trips, FCATS and doctor's appointments.
- Communicate with your child's teacher if your child will need to miss some school regularly to come to therapy for a while. Most teachers want to be helpful and supportive of this process but need to know how they can do so. Don't forget to ask for an excuse note at the front desk if you need one.

---

Parent's Signature

---

Date

---

Client Name

---

Client Number



**Authorization and Consent for Disclosure,  
Receipt, and Use of Confidential Information  
by the Juvenile Welfare Board of Pinellas County**

Child's Name: I, \_\_\_\_\_  
\_\_\_\_\_ (print participant name(s))

acknowledge that I am a participant of \_\_\_\_\_ (name of program or service). I acknowledge that the Juvenile Welfare Board of Pinellas County (“JWB”) provides funds to make the program or service in which I am participating available. I also acknowledge that in order to make sure that all services delivered to participants are of the highest possible quality, JWB may need to review information about me and these services.

By signing this Authorization, I am indicating that I understand and agree that my confidential information may be contained in a JWB data collection system, and that this data collection system is exempt from disclosure under the Florida Public Records Act. This means that by law, JWB cannot release individually identifiable information about me or the services I receive (Fla. Stat. §119.071). I acknowledge that as necessary to carry out the purposes listed herein, JWB may review all information about me, including my participant file and all other information pertaining to me held by the agency providing the program or service, regardless of whether that information is entered into a JWB data collection system. I further acknowledge that JWB is simply storing and reviewing records and information as the payor for these services, and that JWB generally provides no direct services to me, except in certain circumstances may facilitate service delivery I further acknowledge that JWB does not provide medical diagnoses to me and JWB is not a covered entity as that term is defined under HIPAA (the Health Insurance Portability and Accountability Act).

I authorize JWB to utilize my confidential information to verify eligibility for funded services or programs, to facilitate service delivery, make payment for services rendered to me by funded programs or services, quality control of funded services or programs, evidence-based research of JWB funded services or programs, including, but not limited to, tracking outcomes of funded programs and services, and determination of future services/programs funded by JWB. I understand that the confidential information disclosed, received or used by JWB related to my Authorization will not be further disclosed to any other party without my express written consent or as otherwise permitted or required by applicable law unless it is presented in a report that presents information on a group of individuals in de-identified format, which means that no information that identifies me as an individual is revealed.

I acknowledge that this Authorization covers all information about me including, but not limited to, personally identifiable information, Protected Health Information, general medical, general counseling, as well as psychiatric/ psychological/ substance abuse information from my medical health record, any information concerning the performance of any tests, results of those tests, and counseling and treatment records, as allowed by all state, federal and local laws, including, but not



limited to the following: Florida Statutes 394.459, 381.004, and 395.3025; Florida Evidence Code 90.503, 90.5035, and 90.5036; HIPAA, and the Code of Federal Regulations (CFR) Title 42. I consent to my minor participating in online or paper surveys that will be used for program improvements and enhancements. I understand that my records have a privileged and confidential status. I am waiving that status for the purposes contained by this Authorization.

I understand that the confidential information disclosed, received or used by JWB based on this Authorization will not be further disclosed to any other party without my express written consent or as otherwise permitted or required by applicable law. However, the individually identifiable confidential information received by JWB based on this Authorization may be used by JWB and its agents for research purposes, so long as the research results are reported as a whole in de-identified format, which means that no information that identifies me as an individual is revealed. Except, JWB will not provide any records covered by CFR Title 42 to any JWB agents.

I understand that I have the right to withdraw my approval in writing at any time. However, it is possible that JWB may have already relied on this Authorization before it receives notice of my withdrawal and that JWB may have already taken action based on the Authorization. If I do not withdraw my approval, it will automatically end one (1) year from the last day I received services from this program, or with respect to information used in research, or for compliance and quality review activities performed by JWB or its agents, upon completion of the last research project or compliance/ quality review, whatever occurs latest. By my signature below, I acknowledge that I have given my consent as indicated above freely, voluntarily, and without coercion, and that I have been given a copy of this authorization, signed by me on the date shown below.

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

\_\_\_\_\_  
Date

Child's Name: \_\_\_\_\_  
(print participant name)

\_\_\_\_\_  
Effective Date

\_\_\_\_\_  
Signature of Participant or Participant's Authorized Representative (check one):  
 Participant  Parent  Guardian  
 Personal Representative (Legal Documents Required)

\_\_\_\_\_  
(print participant name)

\_\_\_\_\_  
Effective Date

\_\_\_\_\_  
Signature of Participant or Participant's  
Authorized Representative (check one):

- Participant  Parent  Guardian
- Personal Representative (Legal Documents  
Required)

\_\_\_\_\_  
(print participant name)

\_\_\_\_\_  
Effective Date

\_\_\_\_\_  
Signature of Participant or Participant's  
Authorized Representative (check one):

- Participant  Parent  Guardian
- Personal Representative (Legal Documents  
Required)

\_\_\_\_\_  
(print participant name)

\_\_\_\_\_  
Effective Date

\_\_\_\_\_  
Signature of Participant or Participant's  
Authorized Representative (check one):

- Participant  Parent  Guardian
- Personal Representative (Legal Documents  
Required)

\_\_\_\_\_  
(print participant name)

\_\_\_\_\_  
Effective Date

\_\_\_\_\_  
Signature of Participant or Participant's  
Authorized Representative (check one):

- Participant  Parent  Guardian
- Personal Representative (Legal Documents  
Required)

\_\_\_\_\_  
(print participant name)

\_\_\_\_\_  
Effective Date

\_\_\_\_\_  
Signature of Participant or Participant's  
Authorized Representative (check one):

- Participant  Parent  Guardian
- Personal Representative (Legal Documents  
Required)





---

Print Participant Name

---

Participant Signature Date

---

Print Parent/Guardian Name  
(If participant is under 18 years of age)

---

Parent/Guardian Signature Date  
(If participant is under 18 years of age)

---

Print Participant Name

---

Participant Signature Date

---

Print Parent/Guardian Name  
(If participant is under 18 years of age)

---

Parent/Guardian Signature Date  
(If participant is under 18 years of age)

---

Print Participant Name

---

Participant Signature Date

---

Print Parent/Guardian Name  
(If participant is under 18 years of age)

---

Parent/Guardian Signature Date  
(If participant is under 18 years of age)

---

Print Participant Name

---

Participant Signature Date

---

Print Parent/Guardian Name  
(If participant is under 18 years of age)

---

Parent/Guardian Signature Date  
(If participant is under 18 years of age)



**Authorization and Consent for Disclosure,  
Receipt, and Use of Confidential Information  
by the Juvenile Welfare Board of Pinellas County**

---

Adult's Name: I, \_\_\_\_\_ (print participant name(s))

acknowledge that I am a participant of \_\_\_\_\_ (name of program or service). I acknowledge that the Juvenile Welfare Board of Pinellas County (“JWB”) provides funds to make the program or service in which I am participating available. I also acknowledge that in order to make sure that all services delivered to participants are of the highest possible quality, JWB may need to review information about me and these services.

By signing this Authorization, I am indicating that I understand and agree that my confidential information may be contained in a JWB data collection system, and that this data collection system is exempt from disclosure under the Florida Public Records Act. This means that by law, JWB cannot release individually identifiable information about me or the services I receive (Fla. Stat. §119.071). I acknowledge that as necessary to carry out the purposes listed herein, JWB may review all information about me, including my participant file and all other information pertaining to me held by the agency providing the program or service, regardless of whether that information is entered into a JWB data collection system. I further acknowledge that JWB is simply storing and reviewing records and information as the payor for these services, and that JWB generally provides no direct services to me, except in certain circumstances may facilitate service delivery I further acknowledge that JWB does not provide medical diagnoses to me and JWB is not a covered entity as that term is defined under HIPAA (the Health Insurance Portability and Accountability Act).

I authorize JWB to utilize my confidential information to verify eligibility for funded services or programs, to facilitate service delivery, make payment for services rendered to me by funded programs or services, quality control of funded services or programs, evidence-based research of JWB funded services or programs, including, but not limited to, tracking outcomes of funded programs and services, and determination of future services/programs funded by JWB. I understand that the confidential information disclosed, received or used by JWB related to my Authorization will not be further disclosed to any other party without my express written consent or as otherwise permitted or required by applicable law unless it is presented in a report that presents information on a group of individuals in de-identified format, which means that no information that identifies me as an individual is revealed.

I acknowledge that this Authorization covers all information about me including, but not limited to, personally identifiable information, Protected Health Information, general medical, general counseling, as well as psychiatric/ psychological/ substance abuse information from my medical health record, any information concerning the performance of any tests, results of those tests, and counseling and treatment records, as allowed by all state, federal and local laws, including, but not



limited to the following: Florida Statutes 394.459, 381.004, and 395.3025; Florida Evidence Code 90.503, 90.5035, and 90.5036; HIPAA, and the Code of Federal Regulations (CFR) Title 42. I consent to my minor participating in online or paper surveys that will be used for program improvements and enhancements. I understand that my records have a privileged and confidential status. I am waiving that status for the purposes contained by this Authorization.

I understand that the confidential information disclosed, received or used by JWB based on this Authorization will not be further disclosed to any other party without my express written consent or as otherwise permitted or required by applicable law. However, the individually identifiable confidential information received by JWB based on this Authorization may be used by JWB and its agents for research purposes, so long as the research results are reported as a whole in de-identified format, which means that no information that identifies me as an individual is revealed. Except, JWB will not provide any records covered by CFR Title 42 to any JWB agents.

I understand that I have the right to withdraw my approval in writing at any time. However, it is possible that JWB may have already relied on this Authorization before it receives notice of my withdrawal and that JWB may have already taken action based on the Authorization. If I do not withdraw my approval, it will automatically end one (1) year from the last day I received services from this program, or with respect to information used in research, or for compliance and quality review activities performed by JWB or its agents, upon completion of the last research project or compliance/ quality review, whatever occurs latest. By my signature below, I acknowledge that I have given my consent as indicated above freely, voluntarily, and without coercion, and that I have been given a copy of this authorization, signed by me on the date shown below.

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

\_\_\_\_\_  
Date

Adult's Name: \_\_\_\_\_  
(print participant name)

\_\_\_\_\_  
Effective Date

\_\_\_\_\_  
Signature of Participant or Participant's Authorized Representative (check one):  
 Participant  Parent  Guardian  
 Personal Representative (Legal Documents Required)

\_\_\_\_\_  
(print participant name)

\_\_\_\_\_  
Effective Date

\_\_\_\_\_  
Signature of Participant or Participant's  
Authorized Representative (check one):

- Participant  Parent  Guardian
- Personal Representative (Legal Documents  
Required)

\_\_\_\_\_  
(print participant name)

\_\_\_\_\_  
Effective Date

\_\_\_\_\_  
Signature of Participant or Participant's  
Authorized Representative (check one):

- Participant  Parent  Guardian
- Personal Representative (Legal Documents  
Required)

\_\_\_\_\_  
(print participant name)

\_\_\_\_\_  
Effective Date

\_\_\_\_\_  
Signature of Participant or Participant's  
Authorized Representative (check one):

- Participant  Parent  Guardian
- Personal Representative (Legal Documents  
Required)

\_\_\_\_\_  
(print participant name)

\_\_\_\_\_  
Effective Date

\_\_\_\_\_  
Signature of Participant or Participant's  
Authorized Representative (check one):

- Participant  Parent  Guardian
- Personal Representative (Legal Documents  
Required)

\_\_\_\_\_  
(print participant name)

\_\_\_\_\_  
Effective Date

\_\_\_\_\_  
Signature of Participant or Participant's  
Authorized Representative (check one):

- Participant  Parent  Guardian
- Personal Representative (Legal Documents  
Required)



Juvenile Welfare Board of Pinellas County

14155 58th Street North, Suite 100
Clearwater, FL 33760
Phone: 727-453-5600
Fax: 727-453-5610
www.jwbpinellas.org

ADULT'S INFORMATION

Written Statement of Purpose(s) for Collection of Social Security Number for Recipients of JWB-funded Programs and Services

The Juvenile Welfare Board (JWB) invests in partnerships, innovation and advocacy to strengthen Pinellas County children and families. The vision of the JWB is that children in Pinellas County will have a future of more successful and satisfying lives because of the efforts of JWB and its partners. JWB was established by Florida statute in 1945 (Special Act 2003-320: F.S. §189.429) and approved overwhelmingly by voters in a referendum in 1946. JWB was created with a mission to provide needed services to children and families throughout Pinellas County. JWB funds services for children and families in Pinellas County.

The purpose of this document is to provide individuals with written information about how JWB uses the Social Security numbers it collects. JWB is required by Florida's Public Records law [Fla. Stat. §119.071(5)] to provide this information to you.

Florida law allows JWB to collect Social Security numbers in order to carry out its duties and responsibilities prescribed by law (Fla. Stat. §119.071(5) (a) 2a. (II); Special Act 2003-320: F.S. §189.429). Specifically, it is imperative for JWB to collect Social Security numbers to conduct research, fund services, and to ensure that all services delivered to participants are of the highest possible quality.

In addition, collecting Social Security information is necessary to:

- Identify and match individuals and data to research in order to coordinate, plan, and improve services for children and families in Pinellas County;

Social Security numbers held by JWB are confidential and exempt from disclosure except as specifically authorized by law (Fla. Stat. §119.071) (5) (a) 5.). JWB follows the highest security standards. All reports produced by JWB provide information about services in general. No individual person is ever identified in any way in any report without JWB first obtaining that person's written consent.

Adult's Name:

Print Participant Name

Participant Signature Date

Print Parent/Guardian Name (If participant is under 18 years of age)

Parent/Guardian Signature Date (If participant is under 18 years of age)

Print Participant Name

Participant Signature Date

Print Parent/Guardian Name (If participant is under 18 years of age)

Parent/Guardian Signature Date (If participant is under 18 years of age)

---

Print Participant Name

---

Participant Signature Date

---

Print Parent/Guardian Name  
(If participant is under 18 years of age)

---

Parent/Guardian Signature Date  
(If participant is under 18 years of age)

---

Print Participant Name

---

Participant Signature Date

---

Print Parent/Guardian Name  
(If participant is under 18 years of age)

---

Parent/Guardian Signature Date  
(If participant is under 18 years of age)

---

Print Participant Name

---

Participant Signature Date

---

Print Parent/Guardian Name  
(If participant is under 18 years of age)

---

Parent/Guardian Signature Date  
(If participant is under 18 years of age)

---

Print Participant Name

---

Participant Signature Date

---

Print Parent/Guardian Name  
(If participant is under 18 years of age)

---

Parent/Guardian Signature Date  
(If participant is under 18 years of age)

## Finding Your ACE Score

### While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**...  
Swear at you, insult you, put you down, or humiliate you?  
**or**  
Act in a way that made you afraid that you might be physically hurt?  
Yes No If yes enter 1 \_\_\_\_\_
2. Did a parent or other adult in the household **often or very often**...  
Push, grab, slap, or throw something at you?  
**or**  
**Ever** hit you so hard that you had marks or were injured?  
Yes No If yes enter 1 \_\_\_\_\_
3. Did an adult or person at least 5 years older than you **ever**...  
Touch or fondle you or have you touch their body in a sexual way?  
**or**  
Attempt or actually have oral, anal, or vaginal intercourse with you?  
Yes No If yes enter 1 \_\_\_\_\_
4. Did you **often or very often** feel that ...  
No one in your family loved you or thought you were important or special?  
**or**  
Your family didn't look out for each other, feel close to each other, or support each other?  
Yes No If yes enter 1 \_\_\_\_\_
5. Did you **often or very often** feel that ...  
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?  
**or**  
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?  
Yes No If yes enter 1 \_\_\_\_\_
6. Were your parents **ever** separated or divorced?  
Yes No If yes enter 1 \_\_\_\_\_
7. Was your mother or stepmother:  
**Often or very often** pushed, grabbed, slapped, or had something thrown at her?  
**or**  
**Sometimes, often, or very often** kicked, bitten, hit with a fist, or hit with something hard?  
**or**  
**Ever** repeatedly hit at least a few minutes or threatened with a gun or knife?  
Yes No If yes enter 1 \_\_\_\_\_
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?  
Yes No If yes enter 1 \_\_\_\_\_
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?  
Yes No If yes enter 1 \_\_\_\_\_
10. Did a household member go to prison?  
Yes No If yes enter 1 \_\_\_\_\_

**Now add up your "Yes" answers: \_\_\_\_\_ This is your ACE Score.**



## Personal Safety Plan

Your recovery is Directions' top priority. A Personal Safety Plan is a way for your treatment team to know how you would like others to respond if you should begin to feel bad and to help you make choices that won't make things worse.

We want to give you every opportunity to help us understand what works best for you. You are the one who knows that best. Perhaps you can fill this out with your parents/guardians or we can help you share it with them.

Please take a minute to answer the following questions. If you have questions about filling this out, please ask your therapist. If you'd like, you can take this form home and bring it back at your next appointment.

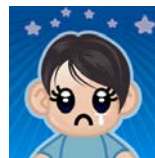


1. When I'm doing well, I usually:

Feel: \_\_\_\_\_

Do (activities/behaviors): \_\_\_\_\_

Sleeping/Eating: \_\_\_\_\_



2. Some of the warning signs that I am not doing well are when I am:

Feeling: \_\_\_\_\_

Doing:(Activities/Behaviors): \_\_\_\_\_

Sleeping/Eating: \_\_\_\_\_

Client Name: \_\_\_\_\_

Client #: \_\_\_\_\_





3. Some things that may cause me to become very upset are:

- a) \_\_\_\_\_
- b) \_\_\_\_\_
- c) \_\_\_\_\_



4. Some of the things that help me to cope when I am upset are:

- a) \_\_\_\_\_
- b) \_\_\_\_\_
- c) \_\_\_\_\_

5. List the people who can help you or you can talk to if you are having a hard time:

- a) \_\_\_\_\_ b) \_\_\_\_\_



- c) \_\_\_\_\_

6. What are 3 things they can do to help you get through a difficult time?



- a) \_\_\_\_\_
- b) \_\_\_\_\_
- c) \_\_\_\_\_

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

Reviewed by:

\_\_\_\_\_  
Signature and Credentials

\_\_\_\_\_  
Date

Client Name: \_\_\_\_\_

Client #: \_\_\_\_\_

For your Child's Safety, a parent or guardian MUST be present for the duration of both therapy and Medication management appointments.

Please do not leave the premises.

Client Name:

Client Number: