Directions for Living
LIFE GETS BETTER HERE.

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: (check one) ☐Puerto Rican ☐Mexican ☐Cuban ☐Other Hispanic ☐Haitian ☐Mexican American ☐Spanish/Latino ☐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 T0 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**
   - **Emergency Procedures**
   - **Client Rights and Responsibilities**
   - **Infectious Disease Control**
   - **Notice of Privacy Practices**
   - **Hours of Operation**
   - **Treatment Services**
   - **Grievance Procedures**
   - **HIV/AIDS Education**
   - **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
 SS#	☐ F ☐ M	☐Mother ☐Father ☐Sibling ☐Guardian					☐ Y ☐ N	☐ Y ☐ N		
 SS#	☐ F ☐ M	☐Mother ☐Father ☐Sibling ☐Guardian					☐ Y ☐ N	☐ Y ☐ N		
 SS#	☐ F ☐ M	☐Mother ☐Father ☐Sibling ☐Guardian					☐ Y ☐ N	☐ Y ☐ N		
 SS#	☐ F ☐ M	☐Mother ☐Father ☐Sibling ☐Guardian					☐ Y ☐ N	☐ Y ☐ N		
 SS#	☐ F ☐ M	☐Mother ☐Father ☐Sibling ☐Guardian					☐ Y ☐ N	☐ Y ☐ N		
 SS#	☐ F ☐ M	☐Mother ☐Father ☐Sibling ☐Guardian					☐ Y ☐ N	☐ Y ☐ N		
 SS#	☐ F ☐ M	☐Mother ☐Father ☐Sibling ☐Guardian					☐ Y ☐ N	☐ Y ☐ N		
 SS#	☐ F ☐ M	☐Mother ☐Father ☐Sibling ☐Guardian					☐ Y ☐ N	☐ Y ☐ N		
 SS#	☐ F ☐ M	☐Mother ☐Father ☐Sibling ☐Guardian					☐ Y ☐ N	☐ Y ☐ N		
 SS#	☐ F ☐ M	☐Mother ☐Father ☐Sibling ☐Guardian					☐ Y ☐ N	☐ Y ☐ N		

Client Name: ______________________________ **Client #:** ______________

9600-018c
Rev. 01/27/2017

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)	Signature of Participant or Participant's Authorized Representative (check one):
Effective Date	○ Participant ○ Parent ○ Guardian ○ Personal Representative (Legal Documents Required)

(print participant name)	Signature of Participant or Participant's Authorized Representative (check one):
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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

CHILD'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.

Child'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)

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

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Authorization and Consent for Disclosure,
Receipt, and Use of Confidential Information
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Adult's Name: I, _____
_____ (*print participant name(s)*)
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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.

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_____ _____

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

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○ Participant ○ Parent ○ Guardian
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ADULT'S INFORMATION

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Adult's Name: _____

Print Participant Name _____ Participant Signature _____ Date

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

Print Participant Name _____ Participant Signature _____ Date

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

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Investing in children. Strengthening our community.

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)
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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: ____0____ This is your ACE Score.

Client Name: Client Number:

Name _____ ENGLISH
Date _____

Modified Simple Screening Instrument for Substance Abuse (MSSI-SA)
Self-Administered Form

Directions: The questions that follow are about your use of alcohol and other drugs, including prescription and over-the-counter medication/drugs. Your answers will be kept private. Mark the response that best fits for you. Answer the questions in terms of your experiences in the past 6 months.

Filling out this form assists us in identifying your needs and providing you with services. Your answers on this form will not exclude you from services, care or treatment at this program.

During the last 6 months…

	Yes	No
1a. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants) --- 1b. Have you used prescription or over-the-counter medication/drugs? (Such as sleeping pills, pain killers, sedatives, or anti-anxiety medication like Valium, Xanax, or Ativan)	----------	----------
2. Have you felt that you use too much alcohol or other drugs? (Other drugs also include prescription or over-the-counter medication more than recommended.)		
3. Have you tried to cut down or quit drinking or using alcohol or other drugs?		
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.)		

5. Have you had any health problems? Please check if you have:
   - ___ Had blackouts or other periods of memory loss?
   - ___ Injured your head after drinking or using drugs?
   - ___ Had convulsions, delirium tremens ("DTs")?
   - ___ Had hepatitis or other liver problems?
   - ___ Felt sick, shaky, or depressed when you stopped?
   - ___ Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?
   - ___ Been injured after drinking or using?
   - ___ Used needles to shoot drugs?

Please continue ⇒

Name _____ ENGLISH
Date _____

Modified Simple Screening Instrument for Substance Abuse (continued)

	Yes	No
6. Has drinking or other drug use caused problems between you and your family or friends?		
7. Has your drinking or other drug use caused problems at school or at work?		

8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.)		
9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?		
10. Are you needing to drink or use drugs more and more to get the effect you want?		
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?		
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break laws, sell things that are important to you, or have unprotected sex with someone?		
13. Do you feel bad or guilty about your drinking or drug use?		

The next questions are about your lifetime experiences.

	Yes	No
14. Have you ever had a drinking or other drug problem?		
15. Have any of your family members ever had a drinking or drug problem?		
16. Do you feel that you have a drinking or drug problem now?		

Thank you for filling out this questionnaire.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	0 ☐	1 ☐	2 ☐	3 ☐

FOR OFFICE CODING 0 + _____ + _____ + 0

=Total Score: 0

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Client Name: Client Number:

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 #: _____

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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: