

ABC Therapy

CLIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name		First Name		Middle Initial	Social Security #
Date of Birth	Age	Home #		Cell #	
Address		City	State	ZIP	
Marital Status (circle one) Single Married Divorced Widowed		Sex (circle one) Male Female		Employer/School	
Emergency Contact (Other than someone that lives with you)		Relationship to you		Phone #	

RESPONSIBLE PARTY INFORMATION (Spouse or Parent)

Last Name		First Name		Middle Initial	Home #	Work #
Employer	Employer's Address				Date of Birth	
Relationship to Patient		Occupation	Department	Social Security #		

PRIMARY INSURANCE INFORMATION

Insurance Company Name		Claims Mailing Address		City	State	ZIP	Phone #
ID#	Group Name and Number		Insured Party		Date of Birth		
Effective Date	Deductible/Copay Information		Deductible Met?	Relationship to Patient			

SECONDARY INSURANCE INFORMATION (if applicable)

Insurance Company Name		Claims Mailing Address		City	State	ZIP	Phone #
ID#	Group Name and Number		Insured Party		Date of Birth		
Effective Date	Deductible/Copay Information		Deductible Met?	Relationship to Patient			

I hereby guarantee payment for the entire balance of the above-named patient. Co-payments and deductibles are due at the time of service. I authorize treatment of the above-named patient. I assign and authorize payment of medical benefits directly to ABC Therapy and/or its representatives. I authorize release of any information, including confidential medical records, requested by insurance companies, payers, or government agencies in connection with this assignment. To cancel an appointment, the above-named patient must notify ABC Therapy at least 24 hours prior to the scheduled appointment time, or else I will be responsible for paying a \$30.00 cancellation fee. I agree to fulfill my financial obligations to the program, including the cost for a collection agency.

I have read, understand, and agree to the described disclosure, financial policy, and various releases and guarantees.

Signature of Responsible Party: _____ Date: _____



ABC Therapy, LLC

Las Vegas 702-598-2020, Henderson 702-568-5971
Mesquite 702-346-3344 & Pahrump 775-727-9749
Abc1@lvcoxmail.com www.abctherapy.net

CONFIDENTIALITY

The confidentiality of alcohol and drug abuse records maintained by this program is protected by Federal law and regulations. Generally, the program may not disclose to a person outside the program that an individual attends the program or disclose any information identifying a person as an alcohol or drug abuser unless:

- A. The client consents in writing and specifies to whom and what information is to be disclosed
- B. The disclosure is allowed by a court order.
- C. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Federal Law and Regulations do not protect any information about a crime committed by a client either at the Program or against any person who works for the program or about any threat to commit such a crime.

Federal Law and Regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

Violation of this Federal Law and Regulations by program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal Regulations. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal Laws and 42 CFR Part 2 for Federal Regulations).

I have read or have had read to me the above statements regarding the laws of confidentiality.

Client Signature

Date



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Medical Record Retention Policy

MEDICAL RECORD RETENTION POLICY - SB 17 is an act relating to retention and destruction of health care records; provisions in the bill stipulate that the health care records of consumers receiving services must be retained for a period of at least five (5) years, or longer as required by federal law; SAPTA requires six (6) years to be in compliance with HIPAA. The records of consumers under the age of 23 years are prohibited from being destroyed until they reach the age of 23; and, require that certain disclosures regarding the destruction of records be provided to consumers.

I, _____ acknowledge receiving a copy to sign of the MEDICAL RECORD RETENTION POLICY. In accordance with the provisions of SB17 of the 2009 Session, health care records of a consumer who is less than 23 years of age may not be destroyed. Records may be destroyed if retained for at least 6 years after the person has reached 23 years of age.

Client Signature

Date

ABC Therapy Staff

Date

ABC Therapy LLC

HIPPA OMNIBUS NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates, their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your counselor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing treatment services to you, to pay your treatment bills, to support the operation of the clinical practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a mental health clinician to whom you have been referred, Drug court vendors (drug testers), your medical provider, case managers, etc., to ensure that the healthcare provider has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your services.

We may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your counselor. We may also call you by name in the waiting room when your counselor is ready to see you.

We may use or disclose your protected health information, as necessary, to contact you to remind of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures.

Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes.

We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any times, in writing, except to the extent that the Drug Court has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information (fees may apply)- Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format.

Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality. You have the right to request a restriction of your protected health information for the purposes of treatment, payment or healthcare operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices.

Your request must state the specific restriction requested and to whom you want the restriction to apply. Your counselor not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request confidential communications – You have the right to request confidential communication from use by alternative means or at an alternative location.

You have the right to request an amendment to protected health information – if we deny your request for amendment, you have the right to file a statement of disagreement with use and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures - you have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to obtain a paper copy of this notice from use event if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

HIPPA COMPLIANCE OFFICER: (Kimberly S. LANDERO, MA, LCADC, LMFT, CPC,SAP, CPGC)

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to the form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Please sign below. Please note that by signing this form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Patient Name

Date



ABC THERAPY

CONSENT FOR SERVICES

____ I volunteer to participate in the ABC Therapy Program.

____ I being the parent/guardian of _____, voluntarily grant consent for the above named person to participate in the ABC Therapy Program.

I grant permission with the understanding/recognition of ABC Therapy as a counseling program whose goal is to facilitate healthy relationships. I accept the responsibility of working toward this goal by participating in any activity that, in the discretion of the clinical team, works towards achieving the objectives put forth.

I understand that I have a right to be informed as to:

- a) The nature and consequences of the recommendation for treatment
- b) The reasonable risks, benefits and purposes of the recommendations for treatment available;
- c) Any alternative recommendation for treatment available to me.

I understand that I may withdraw my consent to any and all parts of the recommendation for treatment and referral, in writing, at any time.

I agree to hold ABC Therapy representatives free from: liability of any which might occur to the above named minor or myself while on the premises of ABC Therapy injury that might occur to the above while being driven by a representative of ABC Therapy to or from the program or any activity; or injury or damages sustained while participating in any program function of ABC Therapy.

I will accept responsibility for payment of any damages done to the property or person by the above named while she/he attends ABC Therapy Program.

This permission and agreement in no way implies that power of attorney is granted to ABC Therapy nor does ABC Therapy assume such power of attorney.

Client Signature

Date

ABC Therapy Staff

Date



ABC THERAPY

Consent for Intern to Diagnose, Assess, and Treat Patient

Name of patient: _____ Date of Birth: _____

Licensed Clinical Social Worker Interns and Marriage and Family Therapists Interns

Prior to obtaining licensure as a Licensed Clinical Social Worker or MFT Interns in the State of Nevada, individuals must complete an internship program in an approved clinical setting.

ABC Therapy is an approved clinical setting, which utilizes interns to diagnose, assess, and treat ABC Therapy's patients.

An on-site supervisor, approved by the State of Nevada, oversees the work of the interns.

The interns are required to maintain patient confidentiality, as required by both federal and state laws.

Consent

I have read the information presented above by ABC Therapy, and hereby consent to a Licensed Clinical Social Worker Intern or a Marriage and Family Therapist Intern conduct my counseling sessions at ABC Therapy.

Patient Signature (including minors)

Date

Spouse Signature

Date

Legal Guardian Signature

Date

ABC Therapy Staff Signature

Date



ABC Therapy LLC

730 N. Eastern Ave, Las Vegas, NV 89101-2885
702-598-2020 702-598-2018
www.abctherapy.net

TELEHEALTH & TELEMEDICINE CONSENT FORM

DEFINITION OF SERVICES:

I hereby consent to engage in telehealth/telemedicine with ABC Therapy LLC. Telehealth/telemedicine is a form of behavioral health and psychiatric service provided via internet technology, which can include consultation, treatment, and transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I understand that telehealth/telemedicine involves the communication of my medical/mental health information, both orally and/or visually. Telehealth/telemedicine has the same purpose or intention as psychotherapy and psychiatric treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions. I understand that I have the following rights with respect to telehealth/telemedicine:

CLIENT'S RIGHTS, RISKS, and AND RESPONSIBILITIES: ?

- I, the client/ Patient, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. ?
- I understand the laws that protect the confidentiality of my medical information also apply to telehealth/telemedicine. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent Form I received at the start of my treatment with ABC Therapy.
- I understand that there are risks and consequences of participating in telehealth/telemedicine, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my provider, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my behavioral health/ medical information could be accessed by unauthorized persons.
- I understand there is a risk that services could be disrupted or distorted by unforeseen technical problems. In addition, I understand that telehealth/telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my provider believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be asked to attend sessions at the agency.
- I understand that I may benefit from telehealth/telemedicine, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my provider, I understand my condition may not improve, and in some cases may even get worse.
- If I am experiencing a crisis, or if I cannot contact ABC Therapy, In case of an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.
- I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in Telehealth/telemedicine. I am responsible for providing the necessary computer, tablet or phone and internet access for my telehealth/telemedicine sessions, and for arranging a location with privacy that is free from distractions or intrusions for my session. It is the responsibility of the treatment provider to do the same on their end.
- I understand that dissemination of any personally identifiable images or information from the telehealth/telemedicine interaction to researchers or other entities shall not occur without my written consent.
- I understand this consent will be reviewed annually.

I HAVE READ, UNDERSTAND AND AGREE TO THE INFORMATION PROVIDED ABOVE REGARDING TELEHEALTH/TELEMEDICINE AT ABC Therapy LLC.

Signature

Date

Staff Signature

Date

ABC Therapy LLC
REQUEST FOR INFORMATION AND/OR
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Information Requested From: _____

Information Released To: _____ I hereby
authorize and/or consent _____ to the disclosure of the information checked below from the records of:

NAME: _____ Date of Birth: _____

Each item or information to be released must be initialed by the client

☐ Discharge Summary	☐ Medication Records	☐ Psychotherapy/Case Management Notes
☐ History & Physical Exams	☐ Physician's Orders	☐ Group Notes
☐ Psychiatric Evaluation	☐ Diagnosis	☐ Consultation reports
☐ Treatment Plans	☐ Intake Evaluation	☐ Lab results (UA's)

Other/specify) _____
For the purpose of: _____

This authorization is effective immediately and is subject to revocation in writing at any time, except to the extent that action has already been taken in reliance thereon. I may revoke this release in writing at any time and without penalty or denial of services.

This authorization expires:

☐ One single disclosure ☐ 90 days from date signed ☐ 1 year from date signed

Other _____

(note: if not checked or indicated by client, this will expire in one year from date from last service date)

It is understood that the policy of the ABC Therapy LLC is to release only that information about a client or a former client, which, in the judgment of the staff, is considered essential to the purposes for which authorization is requested. This in no way binds ABC Therapy LLC to open its records for inspection, or to otherwise provide information which may violate the above policy. Medical Records are protected by Federal Regulations,

Nevada Statutes and/or Administrative Regulations and any further disclosure is prohibited without the consent of the undersigned. ABC Therapy LLC cannot guarantee that further disclosure will not occur.

- A. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefit or enrollment, payment for or coverage of services, or ability to obtain treatment. B. I understand that I may inspect or copy the information used or disclosed.
- C. I understand that I may revoke this authorization at any time by notifying ABC Therapy LLC in writing, except to the extent that:
1. Action has been taken in reliance on this authorization; or
 2. If this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- D. I understand that I have a right to request and receive a Notice of Privacy Practices from ABC Therapy LLC.
- E. I understand that in cases of suspected or known child maltreatment that the providers of ABC Therapy LLC Counseling are mandated reporters under Federal and State law and is legally responsible for reporting such information to Child Protective Services. I understand that my alcohol / drug treatment records are protected under the federal regulations
- F. I understand that my alcohol / drug treatment records are protected under the federal regulations Governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C. F. R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

I further release my clinician, the agency and the employees of the ABC Therapy LLC from any liability arising from the release of information to the person/agency designated above.

_____	_____			
Date	Signature Client			
_____	_____			
Date	Signature	Parent	Guardian	Custodian
_____	_____			
Date	Signature of Witness			



Quality of Life Scale (QOL)

Please read each item and circle the number that best describes how satisfied you are at this time. Please answer each item even if you do not currently participate in an activity or have a relationship. You can be satisfied or not satisfied with not doing the activity or having the relationship. For minors 12 and up should and answer for them self and not by their parent. Note: * (regarding question four, if you are a minor and not pregnant you should be delighted re, question 5 ref, to boyfriend or girlfriend drama. Question 11 refers to school your is to school).

Name:		Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
Date:								
1	Material comforts, home, food, conveniences, financial security	7	6	5	4	3	2	1
2	Health – being physical fit and vigorous	7	6	5	4	3	2	1
3	Relationships with parents , siblings, & other relatives – communicating, visiting, helping	7	6	5	4	3	2	1
4	Having and rearing children	7	6	5	4	3	2	1
5	Close relationships with spouse or significant other	7	6	5	4	3	2	1
6	Close friends	7	6	5	4	3	2	1
7	Helping and encouraging others, volunteering, giving advice	7	6	5	4	3	2	1
8	Participating in organizations and public affairs	7	6	5	4	3	2	1
9	Learning – attending school, improving understanding, getting additional knowledge	7	6	5	4	3	2	1
10	Understanding yourself – knowing your assets and limitations – knowing what life is about	7	6	5	4	3	2	1
11	Work – job or in a home	7	6	5	4	3	2	1
12	Expressing yourself creatively	7	6	5	4	3	2	1
13	Socializing – meeting with other people, doing things, parties, etc...	7	6	5	4	3	2	1
14	Reading, listening to music, or observing entertainment	7	6	5	4	3	2	1
15	Participating in active recreation	7	6	5	4	3	2	1
16	Independence, doing for yourself	7	6	5	4	3	2	1

PLEASE TURN FORM OVER AND COMPLETE THE BRIEF INVENTORIES ON THE OTHER SIDE

Instructions: Indicate how much you've been bothered by each during the past week, including today, by circle in the column that most closely corresponds to how you've been feeling.

mild - *It did not bother me much.*

moderate - *It was very unpleasant, but I could stand it*

severe - *I could barely stand it*

		not at all	mild	moderate	severe
1	Numbness or tingling	0	1	2	3
2	Feeling hot	0	1	2	3
3	Wobbliness in legs	0	1	2	3
4	Unable to relax	0	1	2	3
5	Fear of the worst happening	0	1	2	3
6	Dizzy or lightheaded	0	1	2	3
7	Heart pounding or racing	0	1	2	3
8	Unsteady	0	1	2	3
9	Terrified	0	1	2	3
10	Nervous	0	1	2	3
11	Feelings of choking	0	1	2	3
12	Hands trembling	0	1	2	3
13	Shaky	0	1	2	3
14	Fear of losing control	0	1	2	3
15	Difficulty breathing	0	1	2	3
16	Fear of dying	0	1	2	3
17	Scared	0	1	2	3
18	Discomfort in abdomen	0	1	2	3
19	Faint	0	1	2	3
20	Face flushed	0	1	2	3
21	Sweating (not due to heat)	0	1	2	3

Clinician use only

BAI	
BDI-PC	
QOL	

Instructions: Please pick the one statement from each section that best describes the way you have been feeling during the past 2 weeks, including today. Circle the number beside the appropriate statement.

1 Sadness	I do not feel sad	0
	I feel sad much of the time	1
	I am sad all the time	2
	I am so sad or unhappy I can't stand it	3
2 Pessimism	I am not discouraged about my future	0
	I feel more discouraged about my future than I used to be	1
	I do not expect things to work out for me	2
	I feel my future is hopeless and will only get worse	3
3 Past Failure	I do not feel like a failure	0
	I have failed more than I should have	1
	As I look back, I see a lot of failures	2
	I feel I am a total failure as a person	3
4 Self-Dislike	I feel the same about myself as ever	0
	I have lost confidence in myself	1
	I am disappointed in myself	2
	I dislike myself	3
5 Self-Critical	I don't criticize or blame myself more than usual	0
	I am more critical of myself than I used to be	1
	I criticize myself for all my faults	2
	I blame myself for everything bad that happens	3
6 Suicidal Thoughts Or Wishes	I don't have any thoughts of killing myself	0
	I have thoughts of killing myself, but I would not carry them out	1
	I would like to kill myself	2
	I would kill myself if I had the chance	3
7 Loss of Interest	I have not lost interest in other people or activities	0
	I am less interested in other people or things than before	1
	I have lost most of my interest in other people or things	2
	It's hard to get interested in anything	3



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Minors Consent Form

I (We) have the legal right to authorize, _____ to deliver therapy to my (our) child(ren) listed as part of the medical/ mental health treatment my (our) child(ren) have right to under Nevada law.

Name of child(ren) please print

D.O. B

Under Nevada Law, the following custody arrangements are recognized:

Joint Legal Custody: Both parents equally share the rights and responsibility to make decisions about the child's health, education and welfare. Should the parents not able to agree on such decisions, the parents usually return to mediation to see if they can work out their difference and if cannot work them out through mediation, the matter is presented to the court for the final decision. Both parents have equal right to assess the child (ren) treatment medical/ mental health records and school records.

Sole legal Custody: One parent alone, has the right and responsibility to make all the decisions about the child (ren)'s health, education, and welfare, without any input from the non-custodial parent.

This means that parents who are married to each other have an equal right to consent to Medical /mental health care for the child (ren) of that marriage and have legal joint custody, and only the consent of one parent is required to provide treatment. Even when parents are divorced or were never married, normally the consent of only one parent is required by law if they have legal custody. Only in rare cases, one parent has sole Legal Custody of child (ren).

I (we), hereby, have read and understand the content of the document, which goes into effect as of the _____ day of _____, 20____.

Parent or legal Guardian Signature

Date

ABC Therapy Staff

Date



ABC THERAPY

Formato Para Consentimiento De Menores

Yo (Nosotros) tenemos el derecho legal de autorizar a _____
dar terapia a nuestro (s) hijo/a (s) abajo enlistados como parte del tratamiento medico que mi
hijo/a (s) tiene (n) derecho bajo la ley de Nevada.

Nombre del hijo/a (s) favor de *escribir*

Fecha de Nacimiento

Bajo la ley de Nevada, los siguientes arreglos de custodia son reconocidos:

Custodia Legal Conjunta: Ambos padres comparten por igual los derechos y responsabilidades para tomar decisiones a cerca de la salud, educación y bienestar de los hijos. Si los padres no logran un acuerdo en dicha decisión, los padres normalmente regresan a mediar par a ver si pueden resolver sus diferencias y si no se logra por medio de la mediación, el asunto se presenta a la corte para una decisión final. Ambos padres tienen por igual el derecho de evaluar el tratamiento/registros médicos y escolares de sus hijos.

Custodia Legal Única: Un padre, solo, tiene los derechos y responsabilidades para tomar decisiones a cerca de la salud, educación y bienestar, sin intervención del padre sin derechos de custodia.

Esto significa que los padres que están casados tiene por igual el derecho a consentir el cuidado medico para sus hijos del matrimonio y tienen custodia legal conjunta, y, únicamente se requiere del consentimiento de uno de los padres para proveer el tratamiento. Aun cuando los padres están divorciados o nunca se casaron, normalmente el consentimiento de uno de los padres es requerido por ley si los padres tienen custodia legal conjunta. Solo en casos excepcionales, uno de los padres tiene la custodia legal exclusiva del hijo (s).

Yo (Nosotros), he (mos) leído y entendido el contenido de este documento, el cual toma efecto el día _____ de _____, 20__.

Parent or Legal Guardian Signature

Date

ABC Therapy Staff

Date



ABC Therapy LLC

Confidential Child/Adolescent History Questionnaire (Completed by Parent)

Name (Last, First):		Date of Birth:
School:		Grade:
Father (Last, First):		
Mother (Last, First):		
Date of Marriage:	Date of Divorce (if applicable):	
Date of Death of Parent (if applicable):	Name:	
Current Guardian is: ☐ Natural Parent(s) (above) ☐ Step Parent(s) ☐ Surrogate Parent(s) ☐ Foster Parent(s) ☐ Other:		
Guardian Name (if not natural parent listed above):		

Child/Adolescent's Current Problems (check all that apply):

- ☐ Sleeping disturbance
- ☐ Eating
- ☐ Bedwetting
- ☐ Soiling
- ☐ Seizures or convulsions
- ☐ Speech difficulties
- ☐ Compulsive habits (i.e. tics, nail biting, hair pulling)
- ☐ Limited intelligence
- ☐ Poor social relationships with other family members
- ☐ Poor social relationships with other children
- ☐ Poor social relationships with other adults
- ☐ Resistance to authority
- ☐ Learning problems
- ☐ Mood swings
- ☐ Suicidal thoughts
- ☐ Suicidal gestures, acts
- ☐ Anxieties, fears, phobias
- ☐ Obsessions (repetitive thoughts)

HOW LONG HAVE YOU BEEN AWARE OF THESE PROBLEMS?

- ☐ One month or less
- ☐ One year or less
- ☐ Two years or less
- ☐ Years

(Please Complete Other Side)

- ☐ Depression
- ☐ Social withdrawal
- ☐ Dependency, clinging
- ☐ Suspicion, persecution
- ☐ Delusions (false beliefs)
- ☐ Hallucinations
- ☐ Anger, belligerence
- ☐ Assaultive acts
- ☐ Sexual problems
- ☐ Drug/alcohol problems
- ☐ Anti-social acts, attitudes
- ☐ Hyperactivity, agitation
- ☐ Has difficulty expressing feelings or emotions
- ☐ Inappropriate behavior, appearance, reactions
- ☐ Other physical or emotional problems (explain)

☐	_____
☐	_____
☐	_____

WITH WHOM HAVE YOU DISCUSSED THESE PROBLEMS? PERSON OR PLACE/NAME/WHEN

- ☐ Physician
- ☐ School staff
- ☐ Social agency
- ☐ Clinic or other: _____

- 1 - Mother's pregnancy was: ☐ Normal ☐ Difficult (explain):

Medications used during pregnancy:	
Please mark if there were any uncharacteristic birth issues:	
☐ Duration of Labor	☐ Difficulties, i.e. jaundice
☐ Timeframe the mother was able to see the baby	☐ Need for extra oxygen, resuscitation
	☐ Birth weight
Age of weaning:	Any feeding problems?: ☐ No ☐ Yes (explain):
Approximate age of walking:	Approximate age of talking
Any sleeping problems? ☐ No ☐ Yes (explain):	
Odd behaviors (i.e. head-banging, rocking, etc.):	
Age of toilet training:	
Any problems with toilet training? ☐ No ☐ Yes (explain):	
Does the child have fears or troublesome habits now? Or has he/she had in the past?	
Has the child ever had any severe or long term illnesses or accidents?	
Does the child have any problems about separating from his/her parents, or did he/she ever in the past?	

Medical History

- 1) Name of child's doctor: _____
- 2) Approximate date of child's last physical examination: _____
- 3) Has the child been or presently on any drugs or medications? ☐ No ☐ Yes (please list meds in table):

Name of medication or drug	Dosage	When started	Doctor

Reason for medication or drugs: _____

DOES YOUR CHILD HAVE OR EVER HAD- (CHECK ALL THAT APPLY)

- | | | |
|---|--|--|
| ☐ Diabetes
☐ Allergies
☐ Unusual bleeding
☐ Cancer or tumors
☐ Head injuries
☐ Heart disease | ☐ Reaction to medication
☐ Kidney disease
☐ Liver disease
☐ Thyroid disease
☐ headaches
☐ pregnancy | ☐ other: _____
☐ other: _____ |
|---|--|--|



ABC Therapy LLC
CONFIDENTIAL HISTORY QUESTIONNAIRE FOR ADOLESCENTS
Completed by Adolescent

I. GENERAL INFORMATION

NAME:

ADDRESS:

HOME PHONE:

WORK PHONE:

AGE:

DATE AND PLACE OF
BIRTH:

WERE YOU ADOPTED?
_____ YES _____ NO

ARE YOUR PARENTS DIVORCED?
_____ YES _____ NO

DO YOU HAVE ANY STEPPARENTS?
_____ YES _____ NO

NAMES AND AGES OF BROTHERS AND SISTERS (PLEASE INCLUDE STEP-BROTHERS / SISTERS AND HALF-BROTHERS/ SISTERS:

LIST THE FAMILY MEMBERS THAT LIVE AT HOME WITH YOU:

HAVE YOU EVER BEEN IN TROUBLE WITH THE POLICE? IF YES, FOR WHAT?

_____ YES _____ NO

II. HEALTH

LIST ANY MEDICAL PROBLEMS YOU HAVE HAD, INCLUDING THE TIME FROM BIRTH TO PRESENT:

WHAT MEDICATIONS DO YOU TAKE?

HAVE YOU EVER HAD MENTAL HEALTH COUNSELING OR PSYCHIATRIC TREATMENT IN THE PAST? IF YES, EXPLAIN

_____ YES _____ NO

PLEASE CHECK THE RESPONSE THAT BEST DESCRIBES HOW YOU EXPERIENCE THE FOLLOWING SYMPTOMS:

How often do you have trouble falling asleep or staying asleep all night?

_____ Almost never.

- ☐ About once a week.
- ☐ More than once a week.
- ☐ Almost every day.

I am eating:

- ☐ A little less than usual.
- ☐ A lot less than usual.
- ☐ About the same as usual.
- ☐ A little more than usual.
- ☐ A lot more than usual.

How difficult do you find it to concentrate?

- ☐ I can concentrate well on everything.
- ☐ I can concentrate well only on things that interest me.
- ☐ I can concentrate sometimes, but only on things that interest me.
- ☐ I can't seem to concentrate on anything very well.

How energetic do you feel?

- ☐ Usually I have a lot of energy.
- ☐ Sometimes I feel energetic, sometimes I feel tired.
- ☐ Most of the time I feel tired and it's hard to get myself to do things.
- ☐ Sometimes I have more energy than normal and need less sleep than usual, lasting two days or more in a row.

How often do you think about suicide?

- ☐ Almost never.
- ☐ Sometimes I think about it but I would never consider doing it.
- ☐ I think about it often but I don't think I would go through with it.
- ☐ I think about it and I know exactly how I would do it.

HAVE YOU EVER ATTEMPTED SUICIDE BEFORE? IF YES, WHEN DID YOU ATTEMPT SUICIDE AND WHAT DID YOU DO?

☐ YES ☐ NO

Check the amount of each substance you use:

Beer (12oz can), wine, or liquor?

- ☐ More than one drink per day.
- ☐ More than one drink per week, but less than one drink per day.
- ☐ Less than one drink per week.
- ☐ Almost never.
- ☐ Have never tried beer, wine or liquor.

Marijuana?

- ☐ Daily.
- ☐ Once or twice a week.
- ☐ Less than once a week.
- ☐ Have tried it, but I don't use it regularly.
- ☐ Have never tried marijuana.

Cigarettes?

- ☐ More than 20 cigarettes per day.
- ☐ 10-20 Cigarettes per day.
- ☐ Less than 20 cigarettes per week.
- ☐ Have tried cigarettes, but don't use them regularly.
- ☐ Have never tried cigarettes.

Other drugs (i.e. speed, cocaine, heroine, etc.)?

- ☐ Daily.
- ☐ Once or twice a week.
- ☐ Less than once a week.
- ☐ Have tried other drugs, but I don't use them regularly.
- ☐ Have never taken any other drugs.

Check which substances your parents use:

- ☐ Alcohol
- ☐ Cigarettes
- ☐ Marijuana
- ☐ Other illicit drugs

Are you having sex?

_____ YES _____ NO

Have you ever been sexually abused?

_____ YES _____ NO

Do you have any confusion in regards to your sexual identity?

_____ YES _____ NO

Do you practice safe sex?

_____ YES _____ NO

III. FAMILY

HOW DO YOU GET ALONG WITH YOUR MOTHER?

HOW DO YOU GET ALONG WITH YOUR FATHER?

HOW DO YOU GET ALONG WITH YOUR BROTHERS AND SISTERS?

HOW DO YOUR PARENT'S GET ALONG?

WHICH FAMILY MEMEBERS ARE YOU CLOSEST TO AND WHY?

HAVE YOU EVER RUN AWAY FROM HOME?

_____ YES _____ NO

IF SO, WHEN WAS THIS, WHY DID YOU RUN AWAY AND HOW LONG WERE YOU GONE?

LIST ANY EMOTIONAL OR SUBSTANCE ABUSE PROBLEMS OF RELATIVES:

PROBLEM:	RELATIONSHIP TO YOU:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

WHAT GRADE ARE YOU IN? (CHECK ONE)

__7TH. __8TH __FRESHMAN __SOPHOMORE __JUNIOR __SENIOR __NOT IN SCHOOL

WHAT IS YOUR APPROXIMATE GRADE AVERAGE IN SCHOOL? (CHECK ONE)

___A ___B ___C ___D ___F

WHAT DO YOU LIKE LEAST ABOUT SCHOOL?

WHAT DO YOU LIKE BEST ABOUT SCHOOL?

HAVE YOU EVER DITCHED SCHOOL?

WHAT ARE YOUR FUTURE PLANS FOR SCHOOL, AND CAREER?

CHECK APPROPRIATE DESCRIPTION

ATHLETIC: _____ active _____ average _____ less than average _____ none

GRADES: _____ honor roll _____ average _____ below average _____ varied

POPULARITY: _____ very popular _____ popular _____ average _____ unpopular

DATING: _____ much _____ average _____ little _____ none _____

Other explain:

V. FRIENDS

DO YOU HAVE A BEST FRIEND? _____ YES _____ NO

IF SO, HOW LONG HAVE YOU BEEN CLOSE FRIENDS? _____

WHAT KINDS OF THINGS DO YOU DO WITH YOUR FRIEND? (CHECK ALL THAT APPLY)

_____ Go to concerts and/ or listen to music

_____ Go to the movies

_____ Go to the mall

_____ Eat lunch together at school

_____ Get together on weekend nights

_____ Play sports

_____ Take part in extracurricular activities together (i.e. teams, bands, cheerleading)

_____ Do drugs and drink together

_____ Talk about everything and anything together

_____ Other: _____

DO YOUR PARENTS LIKE YOUR FRIENDS?

_____ YES _____ NO _____ SOME OF THEM

VI. TREATMENT

MAIN REASON FOR SEEKING HELP ARE:

PROBLEMS WOULD BE IMPROVED IF:

DO YOU WANT HELP FOR YOUR PROBLEMS? (CHECK ONE)

_____ Yes _____ Somewhat _____ Could do without

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06



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

1. Did a parent or other adult in the household 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 ...
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
Try to or actually have oral, anal, or vaginal sex with you?
Yes No If yes enter 1 _____
4. Did you 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 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 pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit over 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

Aces Cuestionario (Experiencias adversas durante la niñez)

Nombre de Cliente _____ fecha _____

Antes de sus 18 años

1. Alguno de sus padres o algún adulto en su casa frecuentemente le grito, le insulto, le hizo sentir menos, o le humillo. ¿Se comporto de alguna manera que sintió miedo o físicamente herido?

Si ____ No ____

Si la respuesta es si entre 1 _____

2. Alguno de sus padres o algún adulto en su hogar le empujo, le agarro bruscamente, le dio una bofetada o le tiro algún objeto con frecuencia.

Si ____ No ____

Si la respuesta es si entre 1 _____

3. ¿Algún Adulto u otra persona por lo menos 5 años mayor que usted alguna vez toco su cuerpo, o le obligo a tocar su cuerpo de alguna manera sexual?

Si ____ No ____

Si la respuesta es si entre 1 _____

4. ¿Siente con frecuencia que nadie en su familia le ha querido o pensado que era importante o especial? O que en su familia no se protegían mutuamente, ni eran cercanos entre ustedes, ¿o apoyarse mutuamente?

Si ____ No ____

Si la respuesta es si entre 1 _____

5. ¿Siente Con frecuencia que no tiene comida que tiene que usar ropa sucia, o que no tiene quien lo proteja?

Si ____ No ____

Si la respuesta es si entre 1 _____

6. ¿Perdió alguno de sus padres biológicos como resultado de un divorcio, abandono, o alguna otra razón?

Si ____ No ____

Si la respuesta es si entre 1 _____

7. Alguna vez su Mama o madrastra la empujo, te agarro con brusquedad, te bofeteo, ¿le tiraron algún objeto? O fue pateada, mordida, pegaron con el puno, o con algún objeto duro indique si fue de vez en cuando, ¿o muy frecuentemente?

Si ____ No ____

Si la respuesta es si entre 1 _____

8. ¿Ha vivido con alguien que tiene problemas con el alcohol, es o fue alcohólico, o que consume alguna droga?

Si ____ No ____

Si la respuesta es si entre 1 _____

9. ¿Algún miembro de su hogar sufría de depresión o enfermedad mental, o que haya intentado suicidarse?

Si ____ No ____

Si la respuesta es si entre 1 _____

10. ¿Alguien en su hogar estuvo en prisión?

Si ____ No ____

Si la respuesta es si entre 1 _____

Asumir los puntos de su repuestas de Si y calculando su resultado de ACES _____