Lakefront Wellness Center, S.C.
161 W. Wisconsin Ave. Ste 2B
Pewaukee, WI. 53072
Ph: 262.695.8857 Fax: 262.695.8879
www.lakefrontwellness.com

Teen Patient Questionnaire

Date:_____

Form 4f1adoles1

Welcome, we're glad you're here! Please take time to answer the following questions.
Confidential Record: note that your information will not be released except when we are authorized to do so.

Name:_____ Age:_____ Date of Birth:_____

Home Ph:_____ Sex:_____ Height:_____

Work Ph:_____ Race:_____ Weight:_____

Address:_____

City:_____ State: ***WI*** Zip:_____

Email: _____

How long at this address?_____ With whom do you live?_____

Emergency Contact:_____ Phone:_____

Reason for Seeking Assistance

_____
_____
_____
_____

When did this problem start?_____
What makes this problem better?_____
How will you know when your problem is solved?_____
_____

Health History

Who is your primary physician?_____ What clinic do you attend?_____
When were you last seen by a physician?_____
Are you currently being treated for a medical condition?_____
Please list any medications you are taking now:_____
_____
Do you have any food, drug or environmental allergies?_____
_____
Do you have any medical concerns?_____
_____
How would you describe your eating habits?_____
How would you describe your exercise habits?_____
How do you view your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Social History

Your birthplace (city):_____ Has your family moved often?_____

Where were you raised?_____
Are you adopted? ☐YES ☐NO If yes, what is known about your biological parents?_____

FAMILY MEMBERS

	FIRST NAME	OCCUPATION	MENTAL HEALTH
(Teen's) **Mother**			

Describe your relationship: _____

	FIRST NAME	OCCUPATION	MENTAL HEALTH
(Teen's) **Father**			

Describe your relationship: _____

	FIRST NAME	OCCUPATION	MENTAL HEALTH
(Teen's) **Stepmother**			

Describe your relationship: _____

	FIRST NAME	OCCUPATION	MENTAL HEALTH
(Teen's) **Stepfather**			

Describe your relationship: _____

	FIRST NAME	OCCUPATION	MENTAL HEALTH
(Teen's) **Brothers and Sisters**			

Describe your relationship: _____

	FIRST NAME	OCCUPATION	MENTAL HEALTH
(Teen's) **Step Brothers and Sisters**			

Describe your relationship: _____

Education

Last grade of completion:_____ Are you attending school now? ☐ Yes ☐No

ELEMENTARY, MIDDLE SCHOOL, HIGH SCHOOL

Average grades:_____ Did you make friends easily?_____

Any special education services?_____

_____

Any extracurricular activities?_____

_____

Any discipline/ behavioral problems?_____

_____

Employment

Occupation:_____ What shift?_____

How long have you been at your present job?_____ Any special training?_____

Do you have any current employment concerns?_____

Religion/ Faith

Do you profess a faith? ☐ Yes ☐ No

If yes, what activities do you participate in?_____

_____

Is this an import aspect of your life? ☐ Yes ☐ No Where do you attend activities?_____

Interests, hobbies and recreational activities

Please list any interests, hobbies or recreational activities:_____

_____

_____

_____ _____

Signature of person completing questionnaire Date

_____ _____

Reviewed by (provider) Date

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Parent of Teen Questionnaire (ages 13-18)

Date:_____

Form 4f1adoles2

Welcome, we're glad you're here! Please take time to answer the following questions.
Confidential Record: note that your information will not be released except when we are authorized to do so.

Child's Name:_____ Age:___ Date of Birth:_____
Parent's Name:_____ Age:___ Date of Birth:_____
Parent's Name:_____ Age:___ Date of Birth:_____

Parent's Home Ph:_____ Parent's Work Ph:_____
Parent's Address:_____

Parent's Home Ph:_____ Parent's Work Ph:_____
Parent's Address:_____

Child lives with?/ Placement Schedule: _____

Do you have legal guardianship of this child?_____ If not, please name the person that does:_____

Email:_____

Reason for Seeking Assistance

When did this problem start?_____
What makes this problem better?_____
How will you know when your problem is solved?_____

_____ _____
Signature of person completing questionnaire Date

_____ _____
Reviewed by (provider) Date

Child's Name: _____ **Date:** _____

Person completing this form: _____

Please identify your concerns about this child by placing a number beside a problem, using the choices below. Only rate items when you have a concern. Do not place numbers next to problems about which you have no concerns.

8 = Slight concern but I have *not* thought about getting help for this problem
7 = Some concern *or* I have thought about getting help for this problem
6 = Moderate concern *or* someone has encouraged me to get help for this problem
5 = Serious concern *or* a few people have encouraged me to get help for this problem
4 = Major concern *or* many people have pressured me to get help for this problem
3 = Unable to function *or* the child is totally unable to do what is age-appropriate in this area
2 = A danger to self or others some of the time
1 = A persistent danger to self or others

_____ Abuse or Neglect of Child
_____ Acts without Thinking (Hyperactive or Impulsive)
_____ Aggressive Behavior
_____ Anger
_____ Anxious, Tense, Worried
_____ Arguing with Adults
_____ Arguing with Other Children
_____ Arithmetic
_____ Articulation, Spoken Language
_____ Bad Dreams or Nightmares
_____ Bedwetting
_____ Bothered by Recurring Thoughts
_____ Bothered by Some Trauma
_____ Bullying or Threatening Others
_____ Classroom Behavior
_____ Complains about Not Feeling Well
_____ Coordination
_____ Critical of Self
_____ Daydreaming
_____ Defiant, Oppositional, Noncompliant
_____ Destruction of Property
_____ Divorce of Parents
_____ Eating
_____ Fears or Phobias
_____ Fidgeting, Squirming, "Hyper"
_____ Fighting
_____ Fire Setting
_____ Grief or Bereavement
_____ Health Problems
_____ Homework
_____ Impact of Child's Problems on Parents
_____ Impact of Child's Problems on Siblings
_____ Irritable
_____ Lying
_____ Makes Strange Vocal Sounds
_____ Makes Strange, Jerking Movements
_____ Making or Keeping Friends
_____ Parent–Child Relationship
_____ Paying Attention
_____ Performing Unusual Habits or Rituals
_____ Playground Behavior
_____ Playing or Relating with Other Children
_____ Reading
_____ Refusing to Speak
_____ Relationship with Sibling(s)
_____ Sadness/Depression
_____ School Attendance
_____ School Grades
_____ Self-Injurious Behavior
_____ Sexual Behavior
_____ Shy
_____ Sleeping
_____ Social Skills and Problem Solving
_____ Soiling Underwear
_____ Stealing
_____ Strange, Weird, or Peculiar Behavior
_____ Tantrums
_____ Teased or Victimized by Peers
_____ Weight
_____ Worrying about Being Separated from a Parent
_____ Writing
_____ Other: _____
_____ Other: _____
_____ Other: _____

Child's Name: _____ **Date:** _____

Person completing checklist: _____

In comparison to other children who are your child's age, rate how well your child is doing in each area of life, using the scale as defined below. Record your rating on the line to the left of each area.

Rating Scale

10 = **Excellent Functioning**; top 10%; does better than 9 out of 10 children

9 = **Good Functioning**; next 70%; does as well as the vast majority of children

8 = **Slight Problem**; about 80% of children do better in this part of life than my child; I have slight concern

7 = **Some Problem**; about 90% of children do better in this part of life than my child; I have moderate concern; I have thought about getting help for my child in this part of life

6 = **Moderate Problem**; about 95% of children do better in this part of life than my child; someone has encouraged me to get help for this problem

5 = **Serious Problem**; about 98% of children do better in this part of life; a few people have encouraged me to get help for this problem

4 = **Major Problem**; about 99% of children do better in this part of life; many people have pressured me to get help for this problem

3 = **Unable to Function**; my child is totally unable to do what is age appropriate in this area

2 = **Some Danger to Self or Others**; my child is a danger to self or others some of the time in this area of life

1 = **Persistent Danger to Self or Others**; my child requires constant supervision and is a continuous danger to self or others in this area of life

0 = This item **does not apply** to my child

Areas of Life

	1. Getting along with other children (not counting brothers or sisters)		11. Physical health
	2. Getting along with brother and sisters		12. Happy versus sad or irritable
	3. Relationship with mother		13. Appetite and eating habits
	4. Relationship with father		14. Coordination and athletic ability
	5. Getting along with teachers and other adults		15. Sleeping
	6. School performance		16. Resolving conflicts
	7. Calm versus anxious or worried		17. Musical ability
	8. Artistic ability		18. Chores and responsibilities at home
	9. Grooming, dressing, and hygiene		19. Other:
	10. Ability to entertain or occupy self		20. Other:

FORM 5.14. My Child's Functioning in Everyday Life. From *Outcomes and Incomes* by Paul W. Clement.

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Client's Bill of Rights and Grievance Process
Form 4d

The client has the right to:

- Receive treatment that is respectful, helpful, and free from sexual, physical, and emotional abuse. The treatment should be given in a safe environment and the client can end treatment without obligation or harassment.
- Report unethical and illegal behavior by a therapist.
- Ask questions about therapy services, including alternatives of treatment modalities and possible side effects of medications.
- Request that your therapist make fair and reasonable decisions about your treatment.
- Request and receive full information about the therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations.
- Written information about fees, methods of payment, insurance reimbursement, number of sessions, therapist substitutions (in cases of vacation), and cancellation policies before beginning therapy.
- Refuse to answer any questions you choose not to reveal.
- Refuse electronic recording.
- Know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.
- Know if there are supervisors, consultants, or others with whom your therapist will discuss your case.
- Request, and in most cases, receive a summary of your file; including the diagnosis, progress, and type of treatment.
- Request a transfer of a copy of your file for another therapist or agency.
- Receive a second opinion at any time about your therapy and therapist's methods.
- Not be given unnecessary or excessive medication.
- Not be restrained or placed in a locked room (seclusion) unless in an emergency when it is necessary to prevent physical harm to you or to others.

Records

- Client's treatment information must be kept private and client's records cannot be released without the client's consent unless the law specifically allows for it.
- Clients can ask to see their records. Clients must be shown any records about their physical health or medications. Clients may be limited to how much they may see of the rest of their record while receiving services. Clients must be informed of the reasons for any such limits. Clients can challenge those reasons in the grievance process. After discharge, clients can see their entire record if they ask to do so.
- If clients believe something in their records is wrong, they can challenge the accuracy. If staff will not change the challenged part of a record, clients can put their own version in the record.
- Clients may request their treatment record, in writing, be released to another licensed professional.
- Records shall be destroyed after 7 years.
- Records shall remain in the custody of the clinic if the client's provider leaves employment with the clinic.
- Certain health information is electronic and is transmitted electronically for insurance purposes.

Grievance Resolution Process:

- If you feel your rights have been violated, you may file a grievance. You cannot be threatened or penalized in any way for filing a grievance. The service provider or facility must inform you of your rights and how to use the grievance process. You may, at the end of the grievance process, or any time during it, choose to take the matter to court. The Client Right Specialists at Lakefront Wellness are Dr. Beth A. Johnson and Dr. Peder Piering.

Involuntary Discharge:

- A client may be asked to leave at the discretion of the director for: non-payment, inappropriate behavior, or due to the clinic not being able to sufficiently treat the client due to their unique mental health needs.

I have read and understand the above information about patient rights and grievances.

Patient Signature **Date**

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INFORMED CONSENT AGREEMENT

Form 4c

PURPOSE

The purpose of this agreement is to set forth the basic provisions concerning your treatment provider, admission, treatment, discharge, and follow-up.

UNDERSTANDING

1. Admission to outpatient treatment is voluntary and may be terminated by the patient at any time for any reason. Consent may be withdrawn in writing.
2. You have the right to have your treatment provider make fair and reasonable decisions about your care and participate in your treatment planning.
3. Treatment methods, benefits, and possible alternatives will be explained to you as well as the consequences of not receiving treatment. The risks and benefits will be explained to you. You have the right to decline these treatments.
4. Fees and billing procedures will be explained to you in advance.
5. You will not be recorded or videotaped without your written consent or knowledge.
6. Any testing, reports, consultation, and/or referral procedures will be explained to you.
    a) A copy of your rights as a patient, as approved for under Wisconsin Statute 51.61, has been given to you. These rights explain grievance procedures.
    b) You may ask to see or be seen by your therapist's supervisor.
    c) A copy of this signed form is available to you upon request.
7. Treatment information is considered confidential within certain state and federal limitations.
8. The limits (exceptions) to confidentiality of treatment information are:
    a) To prevent harm or injury to myself or someone else, including child and elder abuse; and
    b) By order of a judge.
9. Your treatment provider may terminate your admission during the course of treatment for the following reasons:
    a) Noncompliance with the course of treatment or violation of clinic rules;
    b) Repeated cancellations or missed appointments;
    c) Not contacting the clinic for 30 consecutive days;
    d) Aggressive or violent behavior toward the therapist or others in the clinic;
    e) If you need services beyond the specialty or knowledge of your treatment provider, in which case your provider will help with a referral;
    f) Refusal to pay or make arrangements for paying, in which case, you have the right to be referred to other services.
10. Lakefront Wellness Center may follow up after treatment with contact by phone, mail or email. _____.

ACCEPTANCE

I, _____, have read/discussed these provisions with my therapist and I do accept the conditions governing my admission, treatment, discharge, and follow-up. This consent is effective from the date of signature for no more than 15 months, at which time it shall be renewed if I wish to continue treatment.

_____ _____

Patient or Guardian Signature **Date**

_____ _____

Witness/Therapist Date

Form Updated April 2003

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INFORMED CONSENT AGREEMENT
ADOLESCENT ADDENDUM
Form 4c1

PURPOSE
The purpose of this agreement is to set forth additional provisions concerning treatment specific to adolescent clients.

Philosophy of treatment behind the development of the adolescent informed consent:

Treatment with adolescents requires a high degree of trust from both the adolescent and the parents/caregivers. Adolescence is a time of individuation marked by increase in the need for privacy and respect of personal information. If an adolescent believes that the information shared in therapy is going to be made available to their parents, they may withhold important pieces; therefore, hindering the therapeutic process. Parents need to trust the therapist's judgment in the balance between sharing information as needed to assist in the safety of the child, and keeping information private as needed to ensure proper relationship development and therapeutic guidance for the child.

UNDERSTANDING
1. Parents/Caregivers allow for confidentiality in treatment given to adolescent children.
2. The limits (exceptions) to this confidentiality include those in the original signed informed consent agreement and may also include other exceptions as listed below:

    a) To prevent the child from engaging in behaviors that could be harmful/risky to self or others.
    b) Information the therapist and adolescent agree may be shared by the therapist to assist parents in appropriate decision making regarding the child.
    c) Information the therapist deems important as it may be crucial to the healthy development and functioning of the adolescent.

3. Lakefront Wellness Center may follow up after treatment with contact by phone, mail or email. _____.

ACCEPTANCE

I, _____, have read/discussed these provisions with my therapist and I do accept the conditions governing my admission, treatment, discharge, and follow-up. This consent is effective from the date of signature for no more than 15 months, at which time it shall be renewed if I wish to continue treatment.

_____ _____
Adolescent Date

_____ _____
Patient or Guardian Signature **Date**

_____ _____
Witness/Therapist Date

Form updated Feb. 2007

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Medical Screening Form
Form 4g1

Client Name: _____ DOB:_____

Current Medical Problem(s):

Current Medication(s): Prescribed by Dr. _____

Past Health Problems:

Past Medication(s): Prescribed by Dr. _____

Date of Last Physician Visit: _____

Name of Current Physician: _____

DO YOU HAVE:

____ Heart Disease
____ Diabetes
____ Cancer
____ Seizures
____ Stroke
____ Tuberculosis
____ Headaches
____ Chest Pains
____ Shortness of Breath
____ Stomach Problems
____ Dietary Restriction
____ Activity Restriction

____ Allergy _____

____ Disability _____

____ Other infectious disease _____

____ Other _____

How to Reach Your Therapist in Case of Emergency
Please Keep this Sheet

Form 8a1

Dear Client,

Your therapist desires to provide service in case of emergency. Examples of emergencies include, but are not limited to, serious changes in mental health, suicidal or homicidal thoughts, threats of abuse to self or others, and reckless behavior. To accommodate emergencies, we maintain accessibility by an urgent notification system in the regular voicemail system. It is activated when you press #71# ***after*** ***you leave your voicemail message on your therapist's voicemail*****. Please remember to leave your name, number and the nature of the emergency. Your therapist may not have your number if you do not leave it.**

Please do not use the urgent notification system for non-urgent situations. During normal office hours (9am -5pm) it is best to also speak directly to the office manager to increase our responsiveness to you. Please note that we cannot guarantee emergency coverage but we will do our best to help you!

Some therapists use texting. Texting or emailing is not the correct way to notify your therapist of your emergency need. Please avoid texting your therapist unless your therapist has texted you to clarify an appointment.

If you or the office manager is unable to reach your therapist in cases of emergency and you need immediate service, we recommend that you call your nearest hospital that provides psychiatric services or present yourself there. We do not anticipate that this would happen but we must be cautious and direct you what to do in advance. We ask that you notify us as soon as possible if you are hospitalized without our assistance. The simplest method of obtaining emergency services is to call **911** but we have prepared a list of local psychiatric hospitals and a few crisis lines.

General Help	
HELPLINE	*414.773.0211*
Domestic Violence	
Advocates "Friends for Victims of Abuse"	*414.375.4034*
Domestic Violence Unit	*414.278.4792*
Compassionate Friends-Waukesha City Chapter	*262.462.3903*
Children and Teens	
Teen Hotline or Dial Harmony (for parents and teens)	*262.547.3388*
Nationwide Girls and Boystown Hotline	*800.448.3000*
Cope Teen Line	*262.377.7786*
Child Adolescent Treatment Center	*414.257.7611*
Child Protective Services	*414.289.6444*
Rogers Memorial Hospital (West Allis)	*414.327.3000*
Rogers Memorial Hospital (Oconomowoc)	*800.767.4411*
Emergency Psychiatric	
Milwaukee City Psychiatric Crisis Service	*414.257.7620*
Columbia St. Mary's Hospital	*800.457.6004 or 414.291.1620*
Community Memorial Hospital	*262.251.1005*
Aurora Psych	*414.454.6600*
Rogers Memorial Hospital (West Allis)	*414.327.3000*
Rogers Memorial Hospital (Oconomowoc)	*800.767.4411*
St. Michael's Hospital	*414.527.8131*
St. Mary's Ozaukee	*262.243.7388*
Waukesha Memorial Hospital	*262.928.4036*