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

Parent/Guardian Questionnaire (ages 12 and under)

Date:_____

Welcome, we're glad you and your child are 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:_____
Race:_____ Weight:_____ Sex:_____ Height:_____
Parent's Email: _____
How long at present address?_____

Name of Emergency Contact: _____ Relationship: _____
Emergency Contact Ph:_____
Referred to us by:_____

Reason for Seeking Assistance

When did this problem start?_____

What have you done in response to this problem (e.g., methods of discipline, treatment, medication)?_____

How will you know when your problem is solved?_____

Has your child currently or previously worked with a mental health professional? (i.e. psychiatrist, psychologist, counselor) in the school or community setting? If so, who, where and when? _____

Health History
Who is their primary physician?_____ What clinic do they attend?_____
When did a physician last see them?_____ When did they last have a physical exam?_____
Are they currently being treated for a medical condition?_____
List any serious illness, injuries, operations, or hospitalizations (include year of occurrence):_____

Please list any medications they are taking now:_____

Do they have any food, drug or environmental allergies?_____

_____

Do you have any medical concerns for them?_____

_____

How would you describe your child's eating habits?_____

How do you view your child's health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Social History

PARENTS RELATIONSHIP STATUS

☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Remarried
☐ Widowed ☐ Significant relationship Number of marriages_____

Child's birthplace (city)_____ Has the family moved often?_____

Where were they raised?_____

Is the child adopted? ☐YES ☐NO If yes, what is known about biological parents?_____

_____

FAMILY MEMBERS	FIRST NAME	AGE	OCCUPATION	YEARS KNOWN	LIVES WITH ✓
Biological Mother					
Significant Other (if applicable)					
Biological Father					
Significant Other (if applicable)					

Describe parental relationships:

_____

_____

_____

DESCRIBE SIBLING RELATIONSHIPS

Brothers and Sisters				
Stepbrothers and Sisters				

Additional Significant People Living in the Home(s):

_____

_____

_____

Education

Your child's current grade:_____ Are they attending school now? ☐Yes ☐No

Current school name/ district:_____

Academic strengths:_____

Any extracurricular activities?_____

Average grades:_____ Current teacher:_____

Any special education services? ☐YES ☐NO If so, what subjects?_____

Is there an active IEP? ☐YES ☐NO Earliest grade IEP began:_____

Any academic performance problems (i.e. homework completion, turning in work, not following instructions)?_____

Any distractibility problems? (i.e. spacing out, forgetfulness, lack of concentration)_____

Any discipline/ behavioral problems? (i.e. fighting, classroom disruption, arguments with adults)_____

Any history of school consequences? (i.e. suspensions, detentions)_____

Religion/ Faith

Do they profess a faith? ☐Yes ☐No Is this an import aspect of their life? ☐Yes ☐No

If yes, what activities do they participate in?_____

Where do you attend activities?_____

Interests, Hobbies and Recreational Activities

List any interests, hobbies or recreational activities:_____

How much time is spent on electronic devices (phone, computer, tablet, television, video game, etc.)?

_____

_____

_____

_____ _____

Signature of parent 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 check beside a problem.

_____ 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
_____ Communication Problems
_____ Complains about Not Feeling Well
_____ Concentration
_____ Coordination
_____ Critical of Self
_____ Cruelty to Animals
_____ Daydreaming
_____ Decreased Energy
_____ Defiant, Oppositional, Noncompliant
_____ Difficulty Going to Bed
_____ Destruction of Property
_____ Divorce of Parents
_____ Eating
_____ Empathy Toward Others
_____ Fears or Phobias
_____ Fear of Leaving the House
_____ Fidgeting, Squirming, "Hyper"
_____ Fighting
_____ Fire Setting
_____ Grief or Bereavement
_____ Health Problems/Somatic Complaints
_____ Homework
_____ Impact of Child's Problems on Parents
_____ Impact of Child's Problems on Siblings
_____ Inability to Sit Still
_____ Intrusive Thoughts (Obsessions)
_____ Irritable
_____ Juvenile Crimes
_____ Loss of Pleasure
_____ Lying
_____ Makes Strange Vocal Sounds
_____ Makes Strange, Jerking Movements
_____ Making or Keeping Friends
_____ Negative Self Statements
_____ Panic Attacks
_____ Parent–Child Relationship
_____ Paying Attention
_____ Performing Unusual Habits or Rituals
_____ Playground Behavior
_____ Playing or Relating with Other Children
_____ Repetitive Behavior (Compulsions)
_____ Restlessness
_____ Reading
_____ Refusing to Speak
_____ Relationship with Sibling(s)
_____ Sadness/Depression
_____ School Attendance
_____ School Grades
_____ Self-Injurious Behavior
_____ Sexual Behavior/Promiscuity
_____ Shy
_____ Sleeping-Insomnia/Hypersomnia
_____ Social Skills and Problem Solving
_____ Soiling Underwear
_____ Stealing
_____ Strange, Weird, or Peculiar Behavior
_____ Tantrums
_____ Teased or Victimized by Peers
_____ Thumb Sucking
_____ Weight-Gain/Loss
_____ Worrying about Being Separated from a Parent
_____ Writing
Other: _____
Other: _____
Other: _____

Thank you for completing this questionnaire. Please turn in the completed form to the office manager or provider.

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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-CHILD VERSION

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. If you share custody and medical decision making with an ex-spouse, we must be made aware of your ex-spouse's contact information. Treatment of children is provided optimally when both parents are informed and involved.
3. If you wish to exclude your ex-spouse from consent to treatment, the child must be carried on your insurance alone. In addition, your ex-spouse will not be held responsible for any payment. Please discuss this with your provider.
4. You have the right to have your child's treatment provider make fair and reasonable decisions about your child's care and participate in your child's treatment planning.
5. 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.
6. Fees and billing procedures will be explained to you in advance.
7. Your child will not be recorded or videotaped without your written consent or knowledge.
8. 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 child's 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 2009

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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*