. . . dedicated to helping the people we serve have a better life
HEALTHCARE TECHNOLOGIES, LLC

Child (Patient) Initial Visit and Screening Information

Child (Patient) Information Section

Last Name	First Name	MI	Date of Birth	Soc. Sec. #
			___/___/____	XXX-XX-__ __ __ __

Gender	Citizenship	Race (□ Mixed - check all that apply)		Ethnicity
□ Male □ Female	□ U.S. Citizen □ Permanent Residence □ Refugee □ Other	□ American Indian □ Alaskan Native □ Asian □ Asian - Indian	□ Black/African American □ Native Hawaiian □ Pacific Islander □ White	□ non-Hispanic/Latino □ Hispanic/Latino

If the child attends school, what grade? (check all that apply)

□ Does not attend school; not old enough
□ Attends daycare
□ "Home School"
□ Kindergarten/pre-school
□ 1st Grade
□ 2nd Grade
□ 3rd Grade
□ 4th Grade
□ 5th Grade
□ 6th Grade
□ 7th Grade
□ 8th Grade
□ 9th Grade
□ 10th Grade
□ 11th Grade
□ 12th Grade

Does the child have any allergies to medications? (if "yes", please list) □ No □ Yes

How would you rate this child's health in general?

Parent or Guardian Section

Parent/Guardian Last Name	First Name	MI	Date of Birth	Soc. Sec. #
			___/___/_____	XXX-XX-__ __ __ __

(☐ Address/Phone Same as Patient)

Current Address - Street/PO Box	Preferred Phone #	Alternate Phone #

City	State	Zip Code	Email Address
	TX		

Are you the child's: □ Mother □ Father □ Grandparent □ Foster parent □ Other relative □ Other

Does the child live in the same household as you? □ Yes □ No (if "no", list where the child lives and who the child lives with)

Insurance Section or Other Funding Source

Insurance or other Payment Source: ☐ Commercial ☐ Medicaid ☐ EAP ☐ Contract ☐ Self ☐ Learning Lab ☐ Other

Insurance company name:

Group/Policy # (if applicable):

Member ID #:

Medicaid # (if applicable):

- If Medicaid; Specify Type: ☐ Traditional ☐ STAR Health (Foster Care) ☐ STAR Plus ☐ CHIP
- If EAP, number of visits authorized: Authorization #:

Name of Primary Insured (if Different than Patient):

Name of Primary Insured's Employer (if applicable):

Copayment Required? ☐ Yes ☐ No   If required, CoPay amount per Visit: $

Prior Authorization Required? ☐ Yes ☐ No   If "Yes", Authorization Number?

Billing Authorization Statements

- I request that payment of authorized insurance benefits, including Medicare and/or Medicaid be made to the organization listed below for any services provided to me by that organization.
- I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for services to the organization, the Health Care Financing Administration, my Insurance Carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my Insurance Company or other entity, if requested. The original authorization will be kept on file by the organization.
- I understand that I am financially responsible to the organization for any charges not covered by my health plan benefits. It is my responsibility to notify the organization of any changes in my health care coverage.
- In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services received.

____ ____/____/______
CLIENT SIGNATURE (or parent/guardian for minor) DATE

CLIENT SOCIAL SECURITY # (or parent/guardian for minor): XXX-XX-__ __ __ __

____ ____/____/______
STAFF SIGNATURE DATE

[Staff: Copy of Insurance Card Attached? ☐ Yes ☐ No]

Appointment Reminders & Permission to Contact

Appointment Reminders

GHT has an appointment reminder service. GHT can enable an automated text message appointment reminder sent to your cell phone the day before your upcoming appointment. We do not charge for this service, however any usual charges you incur for receiving a text message would apply.

☐ No thanks, I do not want a text message appointment reminder.

☐ Yes, I would like to receive a text message appointment reminder. Send the message to:

Phone number: __________________________________

Cell phone carrier (Verizon, Sprint, ATT, etc) ___________________________

Permission to Contact Me

I grant permission to GHT staff to contact me as follows (Check all that apply):

□ By phone & leave a message on voicemail if no answer □ By email
□ By leaving a message with anyone who answers my phone □ By text message

Staff will assist you in completing the Acknowledgments section, please skip for now and go to the next section: History and Background.

Acknowledgment of Privacy Practices, Treatment Planning, Advanced Directives, & Consent to Treatment

Initials ________ *Section A:* I acknowledge receipt of the *Notice of Privacy Practices* of GHT, LLC.

Initials ________ *Section B:* I acknowledge that I am an authorized consenter for this minor and I am providing voluntary general consent to behavioral health treatment and procedures.

Initials ________ *Section C:* I acknowledge participation in treatment planning.

Initials ________ *Section D:* I acknowledge being informed regarding advance directives for mental health in the event that I become incapacitated *(applies to adults only)*.

☐ I do not want to complete an advance directive at this time *or* ☐ I want to complete an advance directive, please provide information

Initials ________ *Permission to Contact Me:* I grant permission to contact me as listed on the Demographic Sheet for GHT, LLC.

____ ____________________
CLIENT SIGNATURE (or parent/guardian for minor) DATE

____
CLIENT SOCIAL SECURITY #

____ ____________________
STAFF SIGNATURE DATE

Patient History & Background

Child / Family History

Child Name: ________________________________

Person Completing History Form: ____

Parent's Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Never Married ☐ Deceased

Mother's Name: _______________________ Age: ____________ Education: _______

Father's Name: _______________________ Age: ____________ Education: _______

Step-parents: ____

Other Household (Family) Members:
Name: Age: Relationship:
_________________________ _________ _________________
_________________________ _________ _________________
_________________________ _________ _________________
_________________________ _________ _________________

Child is: ☐ Biological ☐ Adopted (at age?:____) ☐ Foster Guardian Custody: __________________

Guardian ad litem (if applicable): _____________________________

Visitation Schedule (if applicable): ____

____

Referral Source: ____

Primary Care Provider: ____

Other Treating Medical or Mental Health Providers (If applicable)**:**
Name: Past or Present

____________________________________ ☐ Past provider ☐ Present provider

____________________________________ ☐ Past provider ☐ Present provider

____________________________________ ☐ Past provider ☐ Present provider

Current Mental Health Diagnoses (If applicable)**:** ____

Past Mental Health Diagnoses (If applicable)**:** ____

Current Medications (If applicable)**:** ____

Reason For Referral: ____

Current Concerns (Please check all that apply):

☐ Behavioral
☐ Emotional
☐ Interpersonal
☐ Cognitive
☐ Can't sit still
☐ Nervousness
☐ Conflicts w/ Adults
☐ Concentration Difficulties
☐ Argumentative
☐ Panic Episodes

☐ Conflicts w/ Sibs
☐ Distractibility
☐ Defiant
☐ Phobias
☐ Conflicts w/ Peers
☐ Disorganization
☐ Temper Outbursts
☐ Depression
☐ Lack of Friends
☐ Memory Difficulties

☐ Delinquency
☐ Grief
☐ Poor Social Skills
☐ Learning Probs
☐ Rule Violations
☐ Mood Instability
☐ Inappropriate Social
☐ Language Problems
☐ Impulsivity
☐ Anger

☐ Obsessive Thoughts
☐ Eating Problems
☐ Rage
☐ Fighting
☐ Racing Thoughts
☐ Sleep Problems
☐ Irritability
☐ Cruelty to Others
☐ Compulsive Behav
☐ Low Self Esteem
☐ Negative Peer Group
☐ Alcohol Usage
☐ Drug Usage
☐ School Refusal
☐ Academic Difficulties
☐ Aggression
☐ Lies

☐ History of Legal Problems:
Current:____
Past: ____

Agency Social Worker/Parole Officer, etc: ____

Pregnancy and Birth History

Baby was: ☐ Full term ☐ Premature (______ weeks of gestation)

Birth Weight: ____lbs ____ ozs

Birth Complications (e.g., cord around neck, meconium staining, aspiration, lacking oxygen, jaundice, prolonged labor): ____
____

Apgar Scores if known: ______________ ICU days: ________ Days in hospital: __________

Medical problems after discharge: ____
____
____

Mother - post partum depression?: _____

Developmental History

Motor

Age: Sat alone _____ Crawled _____ Stood _____ Walked _____

Fine Motor Delays (e.g., using scissors, coloring, letter formation, etc.)?: _____
Gross Motor Delays (e.g., running, skipping, biking, playing ball): _____

Handedness: ☐ Right ☐ Left ☐ Both

Family history of left handedness: _____

Occupational Therapy (ages): _________ Physical Therapy (ages): _________________

Speech/Language

Age spoke first word _____ Put 2-3 words together _____

Speech delays/problems (e.g., articulation, stuttering) _________________

Oral motor problems (e.g., late drooling, poor sucking) _________________

Speech/Language Therapy (ages)

Slow to learn alphabet? _____ Name colors? _____ Count? _____

Other language spoken at home (besides English)? ________________________________

Toileting

Age toilet trained: Urine ________ Bowel ________

Problems with: ☐ Daytime wetting ☐ Nighttime wetting ☐ Soiling

Current toileting problems: ____

Educational History

Current School: ____

Primary Teacher/Counselor: ____

Grade: _____Placement: ☐ Regular ☐ Sp. Ed.: ▫ Learning Disorder ▫ Emotional or Behavior Disorder ▫

Substance Abuse ☐ S/L OHI Autism TBI

Any grades skipped/repeated: ____

Teachers report problems in: Check all that apply

☐ Reading ☐ Math ☐ Social Adjustment

☐ Penmanship ☐ Behavior ☐ Organization

☐ Spelling Attention ☐ Written Language ☐ Work Completion

Past history of academic/behavioral difficulties reported by teachers in:

Preschool: ____

Elementary School: ____

____

Middle School: ____

____

High School: ____

____

Social Behavior

Does your child get along with:

Other children: ____

Adults: ____

Have friends: ____

Keep friends: ____

Understand gestures: ____

Understand social cues: ____

Have a good sense of humor: ____

Participate in group activities: ____

Have problems with peer pressure: ____

Medical History

Has vision been checked? _____ Any problems? ____

Has hearing been checked? _____ Any problems? _______________________________________

CT/MRI? Date(s): ____________ Results? ____

EEG? Date(s): ______________ Results? ____

Other tests and results: ____
List serious illnesses/injuries/surgeries/hospitalizations(e.g., psychiatric)/inpatient trt programs:
Date Incident/Location
_______________ ____
_______________ ____
_______________ ____
Is there a history of: Check all that apply

- ☐ Physical/Sexual Abuse Neglect
- ☐ Failure to Thrive
- ☐ Self injurious behaviors
- ☐ Febrile Seizures
- ☐ Staring spells
- ☐ Epilepsy
- ☐ Meningitis/encephalitis
- ☐ Lead poisoning
- ☐ Diabetes
- ☐ Asthma/allergies
- ☐ Abdominal pains/vomiting
- ☐ Headaches
- ☐ Sleep difficulties
- ☐ Migraines
- ☐ Eating problems
- ☐ Loss of Consciousness
- ☐ Clumsiness
- ☐ Frequent ear infections
- ☐ Dizziness
- ☐ Ear tubes
- ☐ Drug allergies
- ☐ Tics/twitching
- ☐ Thyroid problems
- ☐ Repetitive/stereotypic movements
- ☐ Kidney problems
- ☐ Cancer
- ☐ Hypertension

Describe head injuries (e.g., date, reason, loss of consciousness, changes in cognition/behavior:
____
____

Alcohol and Other Drug Abuse History

Does your child/adolescent:
Use caffeine? _____ How much? _____________________________________
Use nicotine? _____ How much? _____________________________________
Use alcohol? _____ How much? _____________________________________
Use marijuana? _____ How much? ___________________________________
Use other drugs? _____ Which ones/how much? _______________________
____

Has your child/adolescent ever been treated for AODA problems? _________
When: _______________________________________
Where: ____

Family History

Please indicate if any or which family members may have had any of the listed problems						
Suicide Attempt(s)	□ *Mother*	□ *Father*	□ *Siblings*	□ *Parents*	□ *Gr Parent*	□ *Other relatives*
Completed Suicide	□ *Mother*	□ *Father*	□ *Siblings*	□ *Parents*	□ *Gr Parent*	□ *Other relatives*
Depression	□ *Mother*	□ *Father*	□ *Siblings*	□ *Parents*	□ *Gr Parent*	□ *Other relatives*
Bipolar Disorder	□ *Mother*	□ *Father*	□ *Siblings*	□ *Parents*	□ *Gr Parent*	□ *Other relatives*
Anxiety Disorder	□ *Mother*	□ *Father*	□ *Siblings*	□ *Parents*	□ *Gr Parent*	□ *Other relatives*
Panic Disorder	□ *Mother*	□ *Father*	□ *Siblings*	□ *Parents*	□ *Gr Parent*	□ *Other relatives*
OCD	□ *Mother*	□ *Father*	□ *Siblings*	□ *Parents*	□ *Gr Parent*	□ *Other relatives*
Schizophrenia	□ *Mother*	□ *Father*	□ *Siblings*	□ *Parents*	□ *Gr Parent*	□ *Other relatives*
ADHD	□ *Mother*	□ *Father*	□ *Siblings*	□ *Parents*	□ *Gr Parent*	□ *Other relatives*
Learning Problems	□ *Mother*	□ *Father*	□ *Siblings*	□ *Parents*	□ *Gr Parent*	□ *Other relatives*
Alcoholism	□ *Mother*	□ *Father*	□ *Siblings*	□ *Parents*	□ *Gr Parent*	□ *Other relatives*
Other Drug Abuse	□ *Mother*	□ *Father*	□ *Siblings*	□ *Parents*	□ *Gr Parent*	□ *Other relatives*
Seizures	□ *Mother*	□ *Father*	□ *Siblings*	□ *Parents*	□ *Gr Parent*	□ *Other relatives*
Thyroid Problems	□ *Mother*	□ *Father*	□ *Siblings*	□ *Parents*	□ *Gr Parent*	□ *Other relatives*
Diabetes	□ *Mother*	□ *Father*	□ *Siblings*	□ *Parents*	□ *Gr Parent*	□ *Other relatives*
Hypertension	□ *Mother*	□ *Father*	□ *Siblings*	□ *Parents*	□ *Gr Parent*	□ *Other relatives*
Cancer	□ *Mother*	□ *Father*	□ *Siblings*	□ *Parents*	□ *Gr Parent*	□ *Other relatives*
Other Neurological	□ *Mother*	□ *Father*	□ *Siblings*	□ *Parents*	□ *Gr Parent*	□ *Other relatives*

Staff Use Only	GHT, LLC Client Case #:	Initial Assmt Date	
	Staff Name	Staff Credentials	Staff ID

Guinn Healthcare Technologies, LLC

Authorization to Release Confidential Information

I authorize Guinn Healthcare Technologies, LLC to disclose to and receive from:

Organization/Person: (List name, address)	Additional Organization/Person: (List name, address)

the following information:

☐ my name and other personal identifying information	☐ progress and compliance with treatment attendance
☐ initial evaluation	☐ date of discharge and discharge status
☐ date of admission	☐ discharge plan
☐ assessment results	☐ employment and training related information
☐ summary of treatment plan	☐ Other: (list)

The purpose of these disclosures is to enable the identified entities to provide or receive information related to assisting with treatment, evaluating and responding to participation and progress, determining my readiness/ability to participate in work, or other purposes. [Describe: ____]

For Substance Abuse Clients: I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that, except for action already taken, I may rescind this consent at any time. If I do not rescind this consent, it expires automatically as follows:

- upon my termination from Guinn Healthcare Technologies, LLC Mental Health and Social Services Programs or three years from the date this consent is signed (whichever comes first)

For Mental Health Clients: I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I also understand that, except for action already taken, I may rescind this consent at any time. If I do not rescind this consent, it expires automatically as follows:

- upon my termination from Guinn Healthcare Technologies, LLC Mental Health and Social Services Programs or three years from the date this consent is signed (whichever comes first)

Patient Consenter Section

______________________________	XXX-XX-_ _ _ _	___/___/___	______________________________
Patient Printed Name	SSN Last 4	Date	Patient Signature * (if patient is a minor, must be signed by parent or guardian)

Parent/Guardian/Consenter Section - ☐ N/A

______________________________	XXX-XX-_ _ _ _	___/___/___	______________________________
Parent/Guardian Printed Name	SSN Last 4	Date	Parent/Guardian Signature

____ ____ ___/___/___

Relationship of Parent /Guardian's to patient listed above: Date

(e.g.; mother, grandmother, father, child welfare agency, etc.)

Consent End Date - Staff Signature Section

Consent End Date: (consents will expire 3 years from the date of client signature unless otherwise specified) ___/___/___

Staff Signature ____ ___/___/___

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42CFR Part 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.