Dear Parent/Guardian,

The packet of information you are receiving is for your student to receive one to one counseling services at his or her school. Two agencies are providing counseling services at Wausau East:

- Bridge Community Health Clinic (Barbie Bunnell, LCSW)
- Peaceful Solutions Counseling (Carla Jones, LCSW & Amy Kluetz, LPC)

School staff have recommended counseling for your child, and may also have suggested one of these therapists to you based on your child's particular needs.

In order for your child to receive these services, you will need to complete our intake form, just as you would if you were actually coming into our agency requesting services for your child. We also have the same privacy laws to follow even though your child will be seen in school. We will need you to sign a release of information for us to talk with school staff about your child's needs, and even to acknowledge your child is seeing us for counseling. The release of information will be helpful for communication between therapist and the school and in coordinating care for your child, but it is NOT a requirement for your child to receive counseling with us at school.

Our therapist will be following up with you to gather information about your child's needs and their history, and will talk with you about setting up appointments in the school, progress your child is making, and to answer questions you may have. There may be times that our therapist asks for your presence at a session, and we will do our best to make that work with your schedule.

Our agencies will provide the same counseling services your child would receive at our agencies. We accept most all insurances, and if there is a concern regarding the cost of the services beyond what your insurance can cover due to high deductibles or insufficient insurance coverage, please contact us and we will help identify possible options to get your child the counseling that has been recommended for them.

- Bridge Clinic Financial Information contact: 715-848-4884; please ask for a Patient Financial Advocate
- Peaceful Solutions Counseling Financial Information contact: 715-675-3458

We look forward to working with you and your child!

Sincerely,

Dakota Kaiser
Behavioral Health Program Director
Bridge Community Clinic
715-848-4884

Lee Shipway
Executive Director
Peaceful Solutions Counseling
715-675-3458

Peaceful Solutions Counseling

741 N 1st Street, Wausau WI 54403

Phone: 715-675-3458 Fax: 715-675-7238

www.peacefulsolutions.org

I HAVE THE PAPERWORK, NOW WHAT?

1) Fill out the following paperwork to the best of your ability

2) Call Peaceful Solutions Counseling at (715) 675-3458 to schedule an intake appointment

   a. Intake appointments are scheduled with the student **and** a parent or guardian.

   b. Intake appointments can take place at Wausau East or at the main office

3) Return the paperwork to your child's school counselor, mail the packet into our main office, or bring the paperwork to your first session

Peaceful Solutions Counseling

BILL OF RIGHTS FOR MENTAL HEALTH/AODA SERVICES
At Peaceful Solutions Counseling

1. You have the right to prompt and adequate treatment.
2. You have the right to be informed in writing about the costs of treatment.
3. You have the right to confidentiality of conversations and records.
4. You have the right to participate in the development of your treatment plan, including benefits, effects and method of treatment.
5. You have the right to be informed about alternatives to treatment.
6. You have the right to refuse any treatment unless a court orders you to receive treatment.
7. You may not be given any medication at our clinic as none of our staff are licensed physicians.
8. You may not be subjected to any drastic treatment measure without your express written, informed consent.
9. You have the right to be treated with dignity and respect, free from verbal or physical abuse.
10. You may not be videotaped, photographed or audio taped without your written consent.
11. You must be treated in the least restrictive manner.
12. You may not be discriminated against because of your race, gender, faith, age disability, sexual orientation or ethnicity.
13. You have the right to complain about your services. A copy of the state's laws about this is available upon request.
14. You have the right to be informed of the expected duration of treatment.

If you believe that one of your rights may have been violated, the agency's clients rights specialist will investigate that matter and attempt to find a resolution if the complaint is validated.

I am encouraged to contact my therapist regarding any concerns I may have during my treatment. I understand that my therapist may be consulting with a supervising mental health practitioner regarding my case and that I may request a meeting with the mental health practitioner.

My signature below indicates that I have been given a copy of the "Information for Clients" sheet, the "Client Rights and the Grievance Procedure for Community Services" brochure and the "Peaceful Solutions Counseling Privacy Notice".

Client Signature: _____ **Date:** _____

Guardian/Parent Signature (if applicable): _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

Peaceful Solutions Counseling

INFORMED CONSENT FOR TREATMENT

I. Treatment method:

Treatment services will be provided through individual, couple, group and family therapy sessions as deemed appropriate and mutually agreed upon by you and your therapist. Collateral contacts with significant others and other involved health care providers may also occur with mutual agreement, as deemed appropriate.

II. Alternative treatment approaches:

Mental Health/AODA therapy incorporates a broad array of theories and techniques for assisting in the resolution of psychological, emotional, and behavioral problems. You always have the option of seeking information from other health care providers regarding their approach or style of therapy.

III. Potential benefits of proposed treatment:

a. Reduction or alleviation of emotional pain related to presenting problem
b. Modification or elimination of self-defeating behaviors
c. Strengthening of self esteem
d. Enhancement of coping, communication, and problem-solving skills
e. Increased satisfaction with interpersonal relationships
f. Improved quality of life

IV. Potential side effects of proposed treatment:

a. Increased awareness of own role in the presenting problem with possible accompanying temporary dip in mood
b. Disruption in one or more key relationships or termination of such relationship(s)
c. Some degree of increased stress and frustration associated with changing long-standing beliefs and behaviors

V. Potential consequences for not receiving proposed treatment:

a. Continuation or worsening of emotional pain related to presenting problem
b. Continuation or further entrenchment of self-defeating behaviors
c. Weakening of self-esteem
d. Continued or increased dissatisfaction with interpersonal relationships
e. Diminished quality of life

VI. Duration of consent validity

a. Your consent to treatment, as indicated by your signature, is considered to be valid and in effect for 12 months from the date signed
b. You have the right to withdraw your consent, in writing at any time

I hereby give my consent to treatment at Peaceful Solutions Counseling according to the agreed upon treatment plan.

Consumer/Guardian Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

Peaceful Solutions Counseling

Telemental Health Informed Consent

Due to the COVID-19 outbreak, Peaceful Solutions Counseling is offering telehealth psychotherapy sessions for the purpose of protecting the physical health of clients and staff members of Peaceful Solutions Counseling. Your therapist will either be providing telehealth in their office at Peaceful Solutions Counseling or at their home in a secure room if the therapist is deemed to be high risk for respiratory issues or is being quarantined.

I understand and agree to receive telemental health services from my therapist. This mean that my therapist and I will, though a live interactive video connection, meet for scheduled psychotherapy sessions under the conditions outlined in this document.

I understand the potential risks of telemental health, which may include the following: 1) the video connection may not work, or it may stop working during a session; 2) the video or audio transmission may not be clear; and 3) I may be asked to go to my therapist's office in person if it is determined that telemental health is not an appropriate method of treatment for me.

I recognize the benefits of telemental health, which may include the following: 1) allowing me to practice safety precautions regarding the COVID-19 outbreak 2) reduced cost and time and commitment for treatment due to the elimination of travel; 3) ability to receive services near my home or from my home; and 4) access to services that are not available in my geographic area.

I give my consent to engage in psychotherapy via videoconferencing. I understand that my therapist uses HIPAA-compliant technology to transmit and receive video and audio and stores all notes and information related to my treatment in a manner that is compliant with state and federal laws. I understand that it is my responsibility to ensure that my physical location during videoconferencing is free of other people to ensure my confidentiality. Furthermore, I understand that recoding my session is prohibited.

I agree to take full responsibility for the security of any communication or treatment on my own computer or electronic device and in my own physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to assess the services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

I understand that I have the option to request in-person treatment at any time, and my therapist will assist in scheduling this or make a referral if travel to the therapist's office is not feasible for me.

I understand the limitations to confidentiality with my therapist include reasonable belief that I am a danger to myself or others. I understand that, if my therapist reasonably believes that I plan to harm myself or someone else, my therapist will contact local emergency services to come to my location and ensure my safety.

My signature indicates that I agree to participation in telemental health under the conditions described in this document.

Client Name (please print): _____ **Date:** _____

Legal Guardian (if applicable): _____

Relationship to client: _____

Client/Guardian Signature: _____ **Date:** _____

☐ **If box is checked: Telemental Health Informed Consent was read to patient (or legal guardian if applicable) and verbal consent was given by the patient or guardian. Therapist initial and date:** _____

Peaceful Solutions Counseling

Peaceful Solutions Counseling, Inc.
741 N 1st St
Wausau, WI 54403
Phone: (715) 675-3458
Fax: (715) 675-7238

Billing Information

Date: _____

Client Name: _____ Age: _____ Date of Birth: _____

Sex: _____ Social Security Number: _____

Phone: _____ Alternative Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Payment Method: _____ Insurance _____ Medical Assistance _____ Self Pay
Fee Amount $_____.00

Insurance Name: _____

Phone Number on Card: _____

Subscriber's Name: _____

Subscriber's Address: _____

Date of Birth (for subscriber): _____ Relationship to Client: _____

Identification Number: _____ Group Number: _____

Address to Mail Claims: _____

Person Responsible for Billing (if different from client):

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Relationship to Client: _____

Dr. Name and Location: _____

Peaceful Solutions Counseling

Discounted/Sliding Fee Application and Agreement

It is the policy of Peaceful Solutions Counseling to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family/household size and annual income. Please complete the following information and bring to your first appointment to determine if you are eligible for a discount. The discount will apply to all services received at this clinic. This form must be completed every 6 months or if your financial situation changes.

If you have private insurance you will be responsible for satisfying any amount left on your deductible. If your insurance does not pay in full once the deductible has been met, you will be responsible for the amount not paid by your insurance company **or** the amount established at the bottom of this fee agreement, whichever is the lesser amount. Provisions exist for reducing or waiving fees below the amount listed on the sliding fee scale, if you request a special waiver. Please note that a request does not change your fee until the Clinic Director approves the waiver.

A mental health or substance abuse initial assessment is $190.00 and ongoing services are billed at the rate of $165.00 per session. If you have Medicaid, Medicare or private insurance we will bill your insurance company for services at the established rate. Please note that a sliding fee scale cannot be used for court related alcohol/drug assessments.

MISSED APPOINTMENTS: With the exception of MA clients, if appointments are not canceled 24 hours in advance, you will personally be billed for the reserved time, for the amount established as your fee. Also note, after 3 no show/no call appointments, services will be terminated. If you arrive for your appointment 15 minutes or more past the scheduled time you will be asked to reschedule your appointment.

Please complete chart below. *Note: Include income from all sources including gross wages, tips, social security, disability, annuities, veteran's payments, alimony, child support, military, and public aid.*

Patient Name:

Number living in Household: _____	Household Income
Self (Income)	_____Yearly/Monthly/Bi-Weekly *(Circle which one)*
Spouse (income)	_____Yearly/Monthly/Bi-Weekly *(Circle which one)*
Dependent children under age 18 (income)	_____ Yearly/Monthly/Bi-Weekly *(Circle which one)*
Total:	_____ Yearly/Monthly/Bi-Weekly *(Circle which one)*

Office Use Only
Based on this information the sliding fee will be: $_____ per session

Current primary method of payment
Insurance____ MA____ FEE____

I certify that the family size and income information above is correct, and that I agree to pay the established fee based on my co-insurance, co-pays and deductibles (if applicable). I also authorize Peaceful Solutions Counseling to release any information necessary to process insurance claims to: _____.
If requested, I am entitled to a list of entities to which my information has been disclosed. This agreement will remain in place for one year of signing this document unless revoked prior to that. I further acknowledge that this information has been reviewed with me and that I have received a copy.

Client or Parent/Guardian's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____

Peaceful Solutions Counseling

Sliding Fee Scale

For services provided by therapists: Initial Session $190.00, Ongoing $165.00

Household Size	Gross Annual Income Levels - Not To Exceed										
1	6,245	12,490	15,613	18,735	21,858	24,980	31,225	37,470	43,715	49,960	56,205
2	8,455	16,910	21,138	25,365	29,593	33,820	42,275	50,730	59,185	67,640	76,095
3	10,665	21,330	26,663	31,995	37,328	42,660	53,325	63,990	74,655	85,320	95,985
4	12,875	25,750	32,188	38,625	45,063	51,500	64,375	77,250	90,125	103,000	115,875
5	15,085	30,170	37,713	45,255	52,798	60,340	75,425	90,510	105,595	120,680	135,765
6	17,295	34,590	43,238	51,885	60,533	69,180	86,475	103,770	121,065	138,360	155,655
7	19,505	39,010	48,763	58,515	68,268	78,020	97,525	117,030	136,535	156,040	175,545
8	21,715	43,430	54,288	65,145	76,003	86,860	108,575	130,290	152,005	173,720	195,435
Discount	95%	90%	85%	80%	75%	70%	60%	50%	40%	30%	20%
Adj Fee	**$ 8.25**	**$ 16.50**	**$ 24.75**	**$ 33.00**	**$ 41.25**	**$ 49.50**	**$ 66.00**	**$ 82.50**	**$ 99.00**	**$ 115.50**	**$ 132.00**

PSC06 (10/1/2019) Effective October 1st, 2019 and subject to yearly revisions

Client Demographics Form

THIS SECTION FOR OFFICE USE ONLY:

Intake date: _____

Marathon County Lincoln County

Other:

SAFE, AODA, Trauma, Mental Health,

CHOICES/County Social Worker

Ins Self Pay MA EAP

1. **Client Name:** _____

2. **Client Gender:**

( ) Female ( ) Male

3. **Client Age:**

( ) 0 - 6 years ( ) 18 – 24 years

( ) 7 –12 years ( ) 25 – 54 years

( ) 13 – 17 years ( ) 55 – 64 years ( ) 65+ years

4. **Client Zip Code:** _____

5. **Client's Race/Ethnicity:**

( ) White/Caucasian
( ) American Indian/ Alaska Native
( ) Native Hawaiian/Pacific Islander
( ) Hispanic or Latino
( ) Asian
( ) Black/African American
( ) Other race/two or more races
( ) Unknown

6. **Annual Household Income:**

( ) Less than $9,500
( ) $9,501 - $12,500
( ) $12,501 - $15,000
( ) $15,001 - $20,000
( ) $20,001 - $25,000
( ) $25,001 - $30,000
( ) $30,001 - $35,000
( ) $35,001 - $40,000
( ) $40,001 - $45,000
( ) $45,001 - $50,000
( ) $50,001 - $55,000
( ) $55,001 - $60,000
( ) $60,001 – more

7. **How many people reside in your household?**

( ) 1
( ) 2
( ) 3
( ) 4
( ) 5
( ) 6
( ) 7
( ) 8

Peaceful Solutions Counseling

INTAKE QUESTIONNAIRE – CHILD

Your responses to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.

Name of person completing form: _____ Date: _____

IDENTIFYING INFORMATION (for individual receiving services)

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Gender: _____

_____ Relationship Status: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Social Security Number: _____ Household Income: $_____

How did you hear about Peaceful Solutions Counseling (PSC)?

- ☐ Church/Religious Affiliation
- ☐ County Department of Social Services/Heath Services/Human Services
- ☐ Department of Corrections/Legal System/Court
- ☐ Employee Assistance Program (EAP)
- ☐ Employer/Co-worker
- ☐ Facebook/Twitter
- ☐ Friend/Relative
- ☐ Hospital/Doctor/Mental Health Provider
- ☐ School
- ☐ United Way's 2-1-1
- ☐ Insurance Company
- ☐ Internet Search
- ☐ PSC Client
- ☐ PSC Employee/PSC Program
- ☐ PSC Website/Brochure
- ☐ Other Social Service Agency
- ☐ Phone Book
- ☐ Self – Returning PSC Client
- ☐ Other: _____

Race:

- ☐ White/Caucasian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Unknown
- ☐ Asian
- ☐ Black/African American
- ☐ Two or more races

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Non-Latino

Language of Choice:

- ☐ English
- ☐ Hmong
- ☐ Russian
- ☐ Laotian
- ☐ Spanish
- ☐ German
- ☐ French
- ☐ Other: _____

Religious Affiliation:

- ☐ Catholic
- ☐ Muslim
- ☐ Jewish
- ☐ Amish
- ☐ Mennonite
- ☐ Protestant (including Lutheran, Methodist, etc.)
- ☐ Non-Denominational
- ☐ No Affiliation
- ☐ Other: _____

Disability:

Do you have a disability? ☐ Yes ☐ No If yes, please specify: _____

If you have a disability, how can the office accommodate your needs?

_____

If you feel that the therapist should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial or ethnic identity, please explain below:

_____

_____

_____

PRESENTING ISSUE (current situation and history)

1. What is the primary issue for which you are seeking help?

	Length of time for issue	Received treatment in the past from:
☐ Parent/Child issues	_____	_____
☐ Over-activity	_____	_____
☐ Grieving	_____	_____
☐ Sibling issues	_____	_____
☐ Peer problems	_____	_____
☐ Abuse or trauma	_____	_____
☐ Behavior problem at home	_____	_____
☐ Eating issues	_____	_____
☐ Anger issues	_____	_____
☐ Depression/Sadness	_____	_____
☐ Sleep Issues	_____	_____
☐ Divorce/Custody issues	_____	_____
☐ Mood swings	_____	_____
☐ Alcohol/drug use	_____	_____
☐ LBGT	_____	_____
☐ Behavior problem at school	_____	_____
☐ Physical Problems	_____	_____
☐ Anxiety or worry	_____	_____
☐ Self-confidence issues	_____	_____
☐ Academic Performance	_____	_____
☐ Harming self (ex: cutting)	_____	_____
☐ Sexual Acting Out	_____	_____
☐ Suicidal Thoughts/Attempts	_____	_____
☐ Other: _____	_____	_____

Additional comments:

_____

_____

2. **Has your child ever been a victim of a crime ? (whether reported or not) (*Some examples might include: Sexual or physical abuse, bullying, etc.)* ___Yes ____ NO**

CURRENT FAMILY INFORMATION

1. Does the child live with parent(s)? ☐ Yes ☐ No

2. If no, where does the child live and with whom? (Names/relationship): _____

_____

3. Has the child lived with anyone else in the past? ☐ Yes ☐ No

4. If yes, with whom and where? _____

_____

5. Parent Information

Father's Name		Phone			
Address		DOB		Age	
Occupation		Education			

Mother's Name		Phone			
Address		DOB		Age	
Occupation		Education			

Step-Father's Name		Phone			
Address		DOB		Age	
Occupation		Education			

Step-Mother's Name		Phone			
Address		DOB		Age	
Occupation		Education			

Foster Father's Name		Phone			
Address		DOB		Age	
Occupation		Education			

Foster Mother's Name		Phone			
Address		DOB		Age	
Occupation		Education			

Guardian/Other Name		Phone			
Address		DOB		Age	
Occupation		Education			

List all other adults living in the home (i.e. aunts, uncles, grandparents, significant others, friends, etc.):

_____

_____

_____

_____

_____

6. Please provide information about the child's brothers and sisters and any other children living in the home:

Name	Gender	DOB	Relationship (full, half, step, foster)	Lives with child?	If no, lives where?
	M F			Yes No	
	M F			Yes No	
	M F			Yes No	
	M F			Yes No	

7. In your current family/household is there a history of: (check all that apply)

☐ Eating disorders ☐ Mental illness ☐ Suicide (attempts or actual) ☐ Physical abuse

☐ Sexual abuse ☐ Emotional abuse ☐ Domestic violence ☐ Custody issues

☐ Incarceration ☐ Gambling ☐ Sexual Addiction ☐ Spending issues

If checked, please explain:

_____

_____

_____

8. The family's strengths are:

_____

_____

_____

9. The family's weaknesses are:

_____

_____

_____

10. The primary disciplinarian in the home is: _____

11. The kind of discipline used with the child is:

_____

_____

12. Are there any family circumstances you would like us to be aware of?

_____

_____

SOCIAL DEVELOPMENT

1. My child gets along with peers:

☐ Poorly ☐ Sometimes ☐ Most of the time ☐ Almost Always

2. My child gets along with adults:

☐ Poorly ☐ Sometimes ☐ Most of the time ☐ Almost Always

3. My child spends the most time with (check closest answer)

☐ Younger children ☐ Same age children ☐ Older children ☐ Adults ☐ Self

4. My child's hobbies and interests are: _____

_____

_____

WORK AND ACADEMIC INFORMATION

1. What school does the child currently attend? _____
2. What grade is the child in? _____
3. School Contact Person/Role: _____
4. Number of schools the child has attended: _____
5. Locations of the schools the child has attended: _____
6. Does the child have a written IEP? ☐ Yes ☐ No
7. Is the child in special education classes? ☐ Yes ☐ No
8. If yes, what type? _____
9. The child is a ☐ Good Student ☐ Average Student ☐ Poor Student
10. Attitudes towards School

☐ Truancy	☐ Argumentative	☐ Fighting with Peers	☐ Poor Effort
☐ Disruptive	☐ Attentive	☐ Repeated Grades	☐ Expulsions
☐ Suspensions	☐ Detentions	☐ Difficulty keeping Friends	☐ Noncompliant
☐ Cooperative	☐ Motivated	☐ Complies with expectations	☐ Interested

11. Is your child currently employed? ☐ Yes ☐ No
12. If yes, where and number of hours per week: _____

ALCOHOL & DRUG HISTORY

Do you suspect/know your child has used drugs or alcohol before or during school?	☐ Yes	☐ No
Do you suspect/know if your child has missed school because of use or just to use?	☐ Yes	☐ No
My child avoids non-users.	☐ Yes	☐ No
Do you suspect/know if your child uses more than one drug to get intoxicated or high?	☐ Yes	☐ No
Is there a history of problems with alcohol or drugs in your family?	☐ Yes	☐ No

If checked yes, please explain: _____

_____

_____

My child is using the following:			How much each time?	How often?
Alcohol	☐ Yes	☐ No	_____	_____
Marijuana	☐ Yes	☐ No	_____	_____
Cocaine/Crack	☐ Yes	☐ No	_____	_____
Heroin	☐ Yes	☐ No	_____	_____
Meth	☐ Yes	☐ No	_____	_____
Tobacco	☐ Yes	☐ No	_____	_____
Hallucinogens: (MDMA, LSD, Psilocybin, Mushrooms, Ecstasy, Ketamine)	☐ Yes	☐ No	_____	_____
Opioids: (Oxycontin, Morphine, Codeine, Vicodin, Tramadol)	☐ Yes	☐ No	_____	_____
Amphetamines: (Adderall, Ritalin, Concerta)	☐ Yes	☐ No	_____	_____
Benzo's: (Xanax, Clonazepam, Ativan)	☐ Yes	☐ No	_____	_____
Party Drugs: (GHB, Rohypnol)	☐ Yes	☐ No	_____	_____
Synthetics: (Bath Salts, K2, Spice, 2-C-T-I)	☐ Yes	☐ No	_____	_____
Other (Specify) _____			_____	_____

Interventions:

A. My child has been involved in a 12 step/AA program? ☐ Yes, currently ☐ Yes, but not currently ☐ No

B. My child has received outpatient AODA treatment? ☐ Yes, currently ☐ Yes, but not currently ☐ No

C. My child has received inpatient AODA treatment? ☐ Yes, currently ☐ Yes, but not currently ☐ No

LEGAL HISTORY

Has your child ever:			When?	For what?
Been arrested	☐ Yes	☐ No	_____	_____
Been convicted	☐ Yes	☐ No	_____	_____
Been on probation	☐ Yes	☐ No	_____	_____
My child is currently:			**For what?**	**For how long?**
On probation	☐ Yes	☐ No	_____	_____

	When?	For how long?
Registered as a sexual offender ☐ Yes ☐ No	_____	_____

Complete if applicable:

Name of child's social worker _____ Phone number: _____

Name of child's PO _____ Phone number: _____

DEVELOPMENTAL HISTORY

1. Pregnancy

Smoking during pregnancy	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently
Alcohol during pregnancy	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently
Drugs during pregnancy	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently

Medication during pregnancy ☐ Yes ☐ No (If yes, list all medications)

_____

2. Labor

☐ Spontaneous ☐ Induced Duration in hours: _____

Complications during pregnancy _____

Birth weight: _____ Infant days in hospital: _____

3. Did the child reach developmental milestones at a normal age?

MEDICAL HISTORY

1. Please check the appropriate box if your child has experienced any of these problems:

☐ Eye disease, injury, poor vision
☐ Ear disease, injury, poor hearing
☐ Nose, sinus, mouth, throat problems
☐ Head injury
☐ Convulsions or seizures
☐ Suicide Attempt
☐ Memory problems
☐ Extreme tiredness or weakness
☐ Thyroid disease or goiter
☐ Skin disease
☐ Heart disease
☐ Back, arm, leg or joint problems
☐ Blood disease
☐ Stomach problems
☐ Premenstrual Syndrome (PMS)
☐ Eating disorder
☐ Liver, gallbladder disease
☐ Cancer
☐ Bowel problems
☐ Hemorrhoids, rectal bleeding
☐ Loss of consciousness
☐ Chest pain or angina pectoris
☐ Frequent or severe headaches
☐ Sleep disturbances
☐ Neck stiffness, pain, swelling
☐ Marked weight changes
☐ Circulatory problems
☐ Allergies or asthma
☐ Diabetes
☐ Encephalitis
☐ Meningitis
☐ Pregnancy not carried to term/stillbirths
☐ High blood pressure
☐ Other _____

Please explain anything checked above: _____

_____

2. Please provide information about medication(s), prescription or over-the-counter, which your child takes regularly:

Medication	Dosage/Frequency	Prescribing Physician	For what condition?

3. Please list significant hospitalizations, operations, injuries (including broken bones): _____

GOALS

1. What are the child's strengths? _____

2. What are the child's weaknesses? _____

3. What goals would you like to see reached as a result of your involvement with Peaceful Solutions Counseling?

4. How will you know when these goals have been reached?