MEIER CLINICS PATIENT REGISTRATION

PATIENT INFORMATION

Name:____
(Last) (First) (Middle Initial) (Nickname)

Mailing Address:____
(Street/PO Box) (Apt./Unit #) (City) (State) (Zip)

Home Phone:_______________ Work Phone:_______________ Ext. #:_______ Cell:_______________

Social Security #:_______________ Sex: ❒M ❒F Birth date:_______________ Age:________

Marital Status: ❒Single ❒Married ❒Divorced ❒Widowed ❒Other _______________

Ethnicity: ❒American Indian/Alaskan Native ❒Asian ❒African/American ❒Hispanic ❒White ❒Hawaiian/Pacific Islander ❒Other_______________

GUARANTOR INFORMATION (Person who is financially responsible)

Name:_______________________________________ Birth date:_______________
(Last) (First) (Middle Initial)

Mailing Address:____
(Street/PO Box) (Apt./Unit #) (City) (State) (Zip)

Relationship to Patient: ❒Spouse ❒Mother ❒Father ❒Sibling ❒Other (relationship) _______________

Home Phone:_______________ Cell Phone:_______________ Soc. Sec. #:_______________

INSURANCE INFORMATION

NOTE: Meier Clinics® ONLY files insurance if your provider is contracted with your insurance plan. Complete the following ONLY if we are filing claims for you.

Primary Insurance Co. Name:_______________________________ Phone:_______________

Subscriber's Name:_______________ Relationship to Pt: ❒Self ❒Spouse ❒Parent ❒Other_______________

Employer:_______________________________ Phone:_______________

Birth date:_______________ Member ID #:_______________ Group ID #:_______________

Secondary Insurance Co. Name:_______________________________ Phone:_______________

Subscriber's Name:_______________ Relationship to Pt: ❒Self ❒Spouse ❒Parent ❒Other_______________

Employer:_______________________________ Phone:_______________

Birth date:_______________ Member ID #:_______________ Group ID #:_______________

CONSENTS TO RELEASE INFORMATION

I hereby consent for Meier Clinics to contact my Primary Care Physician or other health care provider as noted below regarding my treatment, as deemed necessary. This consent shall remain in force during my treatment at Meier Clinics and for 90 days following my last visit unless expressly revoked by me in writing.

Physician Name: _______________________________ Phone #: _______________

Address: ____

- -

I hereby consent for Meier Clinics to contact the person(s) below as deemed necessary regarding the information indicated. This consent shall remain in force during my treatment at Meier Clinics and for 90 days following my last visit or after services have been paid in full unless expressly revoked by me in writing.

Name	Relationship	Daytime Phone #	Evening Phone #	OK to leave message	Financial Info.	Medical Info.	Other (Specify)
				❑	❑	❑	
				❑	❑	❑	
				❑	❑	❑	
				❑	❑	❑	

CONSENT FOR CONTACT VIA E-MAIL

By providing an e-mail below, I hereby consent to the following: •Contact by Meier Clinics via e-mail communication at the personal address below as I am 18 years old or older, or the e-mail provided is that of a parent/legal guardian. •E-mails may be viewed by unintended persons as e-mails are not sent by way of encryption. •E-mail communication may be seen, received and/or responded to by any Meier Clinics staff in order to facilitate the communication. •E-mail is not intended for clinical purposes or a replacement to therapy but may be used as a simple adjunct to therapy or for administrative purposes. •I release and hold harmless Meier Clinics and Meier Clinics staff for any claim(s) I may have, past, present and future, arising from the use of e-mail. •This consent will remain in force during my treatment at Meier Clinics, until all account activity has been successfully completed, or upon receipt of my written revocation.

E-mail Address: ____

ACKNOWLEDGEMENTS

By signing below, I acknowledge the following:

- I have been offered the "Notice of Privacy Policies and Clients Rights."
- I have consented to treatment provided by Meier Clinics and its employees or designees (caregivers). I understand Meier Clinics serves as a training ground for mental health professionals and that I may be seen by an intern who will provide care to me under the supervision of a licensed professional. I authorize the services deemed necessary or advisable by my caregivers to address my needs.
- I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of Meier Clinics. I authorize Meier Clinics to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Meier Clinics may release objective clinical information related to my diagnosis and treatment that may be requested by my insurance company (if applicable) or its designated agent.
- I authorize and request my insurance plan(if applicable) pay directly to Meier Clinics the amount due for services rendered to the patient, myself, or others covered by the above insurance plan(s). I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered. I understand this consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this consent will be null and void six months after the final payment has been received on this account. This consent is subject to state and federal confidentiality regulations.
- I agree to take full responsibility for the entire amount due for any and all services rendered. If the provider is contracted with my insurance company, I will be responsible only for the co-pay, co-insurance, deductible, and non-covered services as determined by the insurance plan. If I do not inform Meier Clinics in a timely manner of any changes to my insurance coverage, I understand that I may need to pay for services in full if payment is denied in part or in full by my insurance carrier. I further understand that I may not be able to schedule appointments if my account becomes delinquent and/or my account is turned over to collections.
- I understand that my patient records are the property of Meier Clinics and shall be treated as confidential; that Meier Clinics will conduct routine patient audits to insure quality record maintenance; that my records will not be released without my written consent or as provided by the laws of the State where I am receiving treatment. I understand that if I choose to have my records or treatment updates provided to a third party, I must request this in writing using Meier Clinics "Authorization for Use and Disclosure of Protected Health Information" form or another acceptable form, with the exception of information I have agreed to release per this Acknowledgement.
- I acknowledge that if I need to cancel or reschedule an appointment I will provide a minimum of one business day's notice. Otherwise, I understand that I am subject to the full charge for the missed appointment and am responsible for payment in full.
- I acknowledge that Meier Clinics is not a 24/7 care facility and that I am responsible for seeking care at my nearest emergency center or through another provider of choice when my Meier Clinics caregiver is not available.
- I certify that all the information I have provided above is true and correct.

Patient Signature: ____ Date: ____________________

Guarantor's Signature (if not patient): ______________________________ Date: ____________________

Patient/Guardian Name (please print if applicable): ____

PLEASE COMPLETE THIS SECTION ONLY IF APPLICABLE

CHILD AND ADOLESCENT CONSENT FOR TREATMENT

I certify that I am the ❒ father, ❒ mother, ❒ legal guardian and have legal custody of the above named patient. I, hereby, give my authorization and consent for the patient to receive outpatient assessment/treatment from ____.
I understand it is the policy of Meier Clinics that the parent/guardian bringing the patient for treatment is responsible for payment at the time services are rendered. I will be responsible for payment of the patient's treatment regardless of any financial arrangement for payment of the patient's medical care, either oral or written, with the patient's other parent or responsible party. I understand that Meier Clinics assumes no responsibility for collecting payment from the other parent or responsible party with whom I may have financial arrangements for the patient's medical care.

Parent/Guardian Name (please print): ____

Parent/Guardian Signature: ____ Date: ____________________

TO BE COMPLETED ONLY BY STAFF Provider:____________________ Appt: ____________________________ Acct. #:______________

Staff Witness: ______________________________Comments:____

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One of the most trusted names in Christian Counseling
1-888-7CLINIC

Patient Preference Regarding Communication of Health Information

Who to Contact

I hereby authorize **Meier Clinics** ("Facility") to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), relative(s), close personal friend(s), and/or others I so designate:

NAME	RELATIONSHIP TO CLIENT	TELEPHONE
NAME	RELATIONSHIP TO CLIENT	TELEPHONE
NAME	RELATIONSHIP TO CLIENT	TELEPHONE
☐ I do not wish to disclose any information with anyone.		

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of *any* medical information.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	TIME

Authorization to Leave Messages

I hereby authorize Meier Clinics to leave messages regarding any medical/mental health condition, such as lab reports and other test results, medications, and appointment reminders on the phone number(s) provided. This authorization will be in effect indefinitely until I revoke it through a written notice.

AUTHORIZED TELEPHONE NUMBER(S):		
☐ HOME ☐ WORK ( ) - ☐ MOBILE	☐ HOME ☐ WORK ( ) - ☐ MOBILE	☐ HOME ☐ WORK ( ) - ☐ MOBILE

I the undersigned understand that I may revoke this consent in writing, care of the Medical Records Custodian. I have read and understand the above information and give my authorization.

PATIENT – SIGNATURE	DATE	TIME

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CONTACT INFORMATION

Child/Adolescent Birthdate

Address City State Zip

Mother Hm Phone Wk/cell Phn

Mother's Address City State Zip

Father Hm Phone Wk/cell Phn

Father's Address City State Zip

Legal Guardian Name Relationship?

Who does the child/adolescent live with?

Relationship

PARENT/LEGAL GUARDIAN QUESTIONNAIRE/PSYCHOSOCIAL

Child and Adolescent Assessment for Ages 15 and Younger

Name of Child/Adolescent: ______________________ Age: ______ Sex: ❒ M ❒ F

Grade: __________ School: ______________________ Ethnicity/Race: ______________

What event(s) or problems have caused you to come for treatment? ______________________

____

____

____

PAST TREATMENT

Has your child ever had any previous mental health treatment? ❒ Yes ❒ No

If so, check which type(s) and the date/age at time of treatment:

- ❒ Psychological Testing: ______________________
- ❒ Individual/Group/Family Therapy: ______________________
- ❒ Psychiatric Hospitalization: ______________________
- ❒ Residential Treatment: ______________________

What was the diagnosis? ______________________

Is your child currently on any medications? ❒ Yes ❒ No

List: ______________________

____

What medications has your child taken in the past for anxiety, depression, ADHD, etc?

List: ______________________

____

____

Do you think any of these medications, past or present, have been effective? ❒ Yes ❒ No

Please explain: ______________________

____

____

____

SYMPTOMS Please check any that apply presently or in the past.

- ❒ Sleep Problems
- ❒ Nightmares
- ❒ Low Energy
- ❒ Concentration Problems
- ❒ Appetite Problems
- ❒ Bingeing/Purging
- ❒ Health Complaints (e.g., headaches, stomach aches)
- ❒ Anger Problems
- ❒ Mood Swings
- ❒ Temper Tantrums
- ❒ Depressed Mood
- ❒ Anxiety/Worry/Panic
- ❒ Obsession/Compulsions
- ❒ Fears
- ❒ Oppositional/Defiant
- ❒ Behavior Problems at School
- ❒ Academic Problems
- ❒ Talk/Thoughts of Death
- ❒ Hurt Self or Others
- ❒ Harm to Animals
- ❒ Alcohol/Drug/Tobacco Use
- ❒ Sexual Acting Out
- ❒ Runaway

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MEDICAL HISTORY

Please rate your child/adolescent in each of the following areas:

	Good	Fair	Poor
Health			
Hearing			
Vision			
Gross Motor Coordination			
Fine Motor Coordination			
Speech Articulation			

Did your child/adolescent experience prenatal exposure to alcohol, tobacco or drugs? ❒ Yes ❒ No

Has your child/adolescent's physical development been normal? ❒ Yes ❒ No

If no, please explain: ______________________________

Has your child/adolescent had any chronic health problems (e.g. asthma, diabetes, heart condition)? ❒ Yes ❒ No

If yes, please explain: ______________________________

Are immunizations current and up to date? ❒ Yes ❒ No

Check which of the following illnesses your child/adolescent has had:

❒ Mumps ❒ Chicken Pox ❒ Measles ❒ Whooping Cough ❒ Scarlet Fever ❒ Pneumonia ❒ Seizures
❒ Encephalitis ❒ Otitis Media ❒ Lead Poisoning ❒ Other ______________________________

How many accidents has your child/adolescent had? ❒ One ❒ 2-3 ❒ 4-7 ❒ 8-12 ❒ over 12

Check if your child/adolescent has had any accidents resulting in the following:

❒ Broken Bones ❒ Head Injury ❒ Stomach Pumped ❒ Lost Teeth ❒ Eye Injury ❒ Severe Lacerations
❒ Stitches ❒ Severe Bruises ❒ Other ______________________________

Check if your child/adolescent has had surgery for any of the following conditions:

❒ Tonsillitis ❒ Appendicitis ❒ Leg Or Arm ❒ Burns ❒ Adenoids ❒ Digestive Disorder ❒ Hernia
❒ Eye, Ear, Nose or Throat ❒ Urinary Tract ❒ Other ______________________________

Does your child/adolescent have bladder control problems?

At night? ❒ Yes ❒ No If yes, how often? ______________________________
During the day? ❒ Yes ❒ No If yes, how often? ______________________________

Does your child/adolescent have bowel control problems?

At night? ❒ Yes ❒ No If yes, how often? ______________________________
During the day? ❒ Yes ❒ No If yes, how often? ______________________________

Has your child/adolescent ever been diagnosed with a medical problem? ❒ Yes ❒ No

If yes, what and how treated? ______________________________

____
____
____
____

What are your child/adolescent's current medical needs? ______________________________

____
____
____
____
____
____

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SEXUAL MATURATION HISTORY

At what age did your child/adolescent show adult body development? ______________________________

At what age did your daughter begin menstruating? ______________________________

Were there any special problems with the onset of menstruation/body development? ❒ Yes ❒ No

Does your child/adolescent appear appropriately comfortable with the opposite sex? ❒ Yes ❒ No

Is your child/adolescent sexually active? ❒ Yes ❒ No ❒ Don't Know

Have there been any pregnancies or abortions? ❒ Yes ❒ No ❒ Don't Know

Has your child/adolescent ever been the recipient of or perpetrator of neglect, violence, or sexual abuse? ❒ Yes ❒ No

If yes, please explain: ______________________________

____

____

Additional Comments: ______________________________

____

____

SCHOOL HISTORY

Indicate any of the following school problems that apply.

	During what grade(s)?
Oppositional	
Disrupt class	
Inattentive	
Refuse to go to school	
Fail to turn in work	
Disorganized	
In-school suspension	
Out-of-school suspension	
Expelled from School	

Has your child/adolescent ever had problems with his or her learning ability? ❒ Yes ❒ No

If yes, please explain: ______________________________

____

Summarize your child/adolescent's progress (e.g. grades, academic, social, behavioral) within each of the following grade levels. Also list whether your child/adolescent attended public, private or home school.

Preschool: ______________________________

Kindergarten: ______________________________

Grades 1-3: ______________________________

Grades 4-6: ______________________________

Middle School/Junior High: ______________________________

High School: ______________________________

Have instructional modifications been attempted? ❒ Yes ❒ No

If yes, please list: ______________________________

____

Has your child/adolescent had any educational testing? ❒ Yes ❒ No

If yes, please list: ______________________________

____

What is your child's learning style? ______________________________

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SOCIAL HISTORY

How does your child/adolescent get along with his/her brothers/sisters?

❒ Better than average ❒ Average ❒ Worse than average ❒ Doesn't have any siblings

How easily does your child/adolescent make friends?

❒ Easier than average ❒ Average ❒ Worse than average

About how many close friends does your child/adolescent have?

❒ None ❒ 1 ❒ 2 or 3 ❒ 4 or more

On the average, how long does your child/adolescent keep friendships?

❒ Less than 6 months ❒ 6 months – 1 year ❒ 2 years or more

Describe your child socially:

❒ Withdrawn ❒ Insecure ❒ Outgoing ❒ Passive ❒ Aggressive ❒ Other ______________________

What extracurricular activities is your child/adolescent involved in? ______________________________________

____

What jobs or chores does your child/adolescent have? ____

____

Has your child/adolescent ever had any legal problems? ❒ Yes ❒ No

If yes, please explain: ____

____

Are you aware of any alcohol, tobacco, and/or other drug use by your child/adolescent? ❒ Yes ❒ No

If yes, please explain: ____

____

RELIGIOUS/FAITH HISTORY

What is your family's religious background? ____

Does your child/adolescent currently attend religious services? ❒ Yes ❒ No

If yes, where? ____

Please list any issues (positive or negative) that are important or may have affected your child in regard to faith:

____

____

____

____

FAMILY HISTORY

Check if there is any history of the following in the family. If yes, write in who (e.g., mother, grandfather, aunt, etc.)

	Who		Who
Learning Disabilities		Physical or Sexual Abuse	
ADD/ADHD		Psychosis or Schizophrenia	
Mental Retardation		Tics or Tourettes	
Depression		Bipolar Disorder (Manic Depression)	
Anxiety Disorder		Birth Defects	
Alcohol or Drug Abuse		Diabetes	
Arrests		Suicide Attempts/Suicide	

Who has legal custody of your child/adolescent? ____

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Current living situation of child/adolescent:

❒ Both parents' home ❒ Relative's Home
❒ One parent's home ❒ Friend's Home
❒ Legal guardian's home ❒ Other ______________________________

Primary living situation for past year:

❒ Both parent's home ❒ Relative's Home
❒ One parent's home ❒ Friend's Home
❒ Legal guardian's home ❒ Other ______________________________

Please describe the family home: ❒ House ❒ Apartment ❒ Condo Other ____________________

Number of rooms ______ Number of bathrooms ______ Number of bedrooms ______

Please indicate who sleeps in each bedroom: ______________________________

____

Please describe your neighborhood: ______________________________

____

Who has taken care of your child/adolescent most of their life? ______________________________

____

Who is the primary disciplinarian in the family? ______________________________

Are they: ❒ Strict ❒ Lenient

Do parents agree on the issues of parenting, rules and discipline? ❒ Always ❒ Usually ❒ Sometimes ❒ Rarely

What strategies have been used to address problems? (Check those that apply and circle those that have been successful):

❒ Verbal Reprimands ❒ Time Out ❒ Removal of Privileges ❒ Rewards
❒ Physical Punishment ❒ Giving In To your child ❒ Avoiding your child

On the average, what percentage of time does your child/adolescent comply with initial commands?

❒ 0-20% ❒ 21-40% ❒ 41-60% ❒ 61-80% ❒ 81-100%

On the average, what percentage of the time does your child/adolescent eventually comply with commands?

❒ 0-20% ❒ 21-40% ❒ 41-60% ❒ 61-80% ❒ 81-100%

Do parents get along with one another? ❒ Always ❒ Usually ❒ Sometimes ❒ Rarely

Have there been or are there currently any major changes or stresses in the family where your child was raised?

❒ Yes ❒ No If yes, please check all the following that apply:

	In past	Current (6 months or less)
Financial problems		
Frequent moves		
Job changes		
Drinking and/or drug problems		
Arguments between parents/partners		
Separation or divorce of parents		
Remarriage of parent(s)		
Separation from sibling(s)		
Frequent physical punishment		
Physical confrontations between parents/partners		
Mental illness in family		
Physical illness in family		
Psychiatric hospitalization of a parent/partner		
Death in the family		
Incestuous behavior in family		
Other: Explain		

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What are the family's strengths? ______________________________

What are the family's weaknesses? ______________________________

What are your child/adolescent's strengths? ______________________________

What are your child/adolescent's weaknesses? ______________________________

What do you see as an issue(s) important to your child/adolescent? ______________________________

Please mark any of the statements below that apply to your family:

	Yes	No
Our family is warm and loving.		
People are often arguing in our family.		
Everyone goes his or her own separate way.		
Family members say what is on their minds.		
Our family hides things.		

What would you like to change about your family? ______________________________

How has the family been changed by your child/adolescent's problem(s)? ______________________________

What is the family's expectation of treatment? ______________________________

What does the family see as their role in treatment? Which family members are willing and able to participate?

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List any disabilities or disorders that your child/adolescent has that were not previously mentioned?

Describe your child/adolescent's adjustment to these disabilities and/or disorders.

Is there a need for assistive technology in the treatment of your child/adolescent? ❒ Yes ❒ No
If yes, what is that need?

Is there anything else about your child/adolescent or family that we should know in order to be more helpful?

***Note**: Bring this form, as well as psychological or educational test results, report cards, behavior modification charts and any other pertinent documents to your next appointment.*

(Parent/Legal Guardian Signature) (Date)

Read and Reviewed by
(Clinician) (Date)

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Meier Clinics

Adolescent Questionnaire

NOTE: THIS FORM IS OPTIONAL! Any information you give me would help me to know more about you (rather than just what your parents say about you). If you would rather not, please feel free to answer only part or none of the questions.

Name ____ Age ___________________

How do you feel about being here?

( ) It's fine with me
( ) I don't care either way
( ) I'm against it

Have you ever seen a counselor before? ( ) Yes ( ) No

What event(s) or problems have caused you to come for counseling?________________________

____

____

Health

Check all that apply to you:

( ) I have difficulty falling asleep.
( ) I wake up frequently during the night.
( ) I wake up very early and can't get back to sleep.
( ) I feel tired much of the time.
( ) I have gained or lost 10 lbs. or more within the past 2 months.
( ) I sometimes eat way too much or feel my eating is out of control.
( ) I sometimes vomit after eating too much to get rid of the food.
( ) I have a hard time concentrating.
( ) My memory is not as good as it used to be.
( ) I have stomach aches or headaches a lot.
( ) I have thoughts that trouble me sometimes.
( ) I worry a lot.
( ) Sometimes I wish I didn't have to go on living.

Check below the three (3) feelings you most often have:

( ) happy
( ) irritable/"touchy"
( ) confused
( ) "hyped up"/energetic
( ) worried
( ) sad
( ) anxious/nervous
( ) confident
( ) guilty
( ) lonely
( ) angry
( ) bored
( ) shy
( ) depressed
( ) worthless

List any medications you are currently taking: ______________________________________

School

What school do you go to? ____

What grade are you in? ______________

What activities (if any) are you in at school (such as sports, music etc.)? ________________

____

What do you like the most about school? ____________________________________

What do you like the least about school? ____________________________________

Activities and Interests

What do you do for fun? ____

What activity would you like to do that you haven't done yet in your life? ______________

____

Friendships & Relationships

How much time do you spend with others your age? ( )a lot of time ( )some time ( )not much time

Do you have a "best" friend? ( ) Yes ( ) No

If so, how long have you known him/her? _______________________________

Do you have a boyfriend/girlfriend? ( ) Yes ( ) No

If so, how long have you been dating? ____________________________________

Do people at school tend to label your group of friends (e.g. skaters, metalheads, preps, etc.)?

( ) Yes ( ) No

If so, what label would you usually be given?

____

Do you have someone you can talk to about personal issues in you life? ( ) Yes ( ) No

If so, who? ____

How do you generally think of adults? (Please check all that apply)

( ) helpful
( ) friendly
( ) overly strict
( ) smart or wise most of the time
( ) can be trusted and counted on
( ) usually mean
( ) out of touch with you
( ) caring
( ) jerks
( ) stupid or dumb most of the time
( ) can't be trusted or counted on

Drug and Alcohol Use

	never	tried	rarely	monthly	weekly	daily
How often do you drink?	( )	( )	( )	( )	( )	( )
Smoke cigarettes?	( )	( )	( )	( )	( )	( )
Smoke marijuana?	( )	( )	( )	( )	( )	( )
Use cocaine/crack?	( )	( )	( )	( )	( )	( )
Use acid/LSD?	( )	( )	( )	( )	( )	( )

Tried other drugs? (Please list) ____

Family

Describe your family in a few words: ____

____

Who do you get along with the best in your family? ___________________________

______

What would you change about your family if you were given the power to do so? __________

____

Faith

Do you currently attend church, synagogue, or mosque? ( ) Yes ( ) No

Are you involved in a religious youth group? ( ) Yes ( ) No

Have you had any positive or negative experiences related to your faith? ( ) Yes ( ) No

Please List: ____

General

What is your earliest memory from childhood? _____________________________

____

Please list any major changes in your life over the past five (5) years (e.g., moving, parents divorced, etc.): ____

____

Is there anything else you want me to know about you? _______________________

____

____

_________________________________ _______________

Signature Date