Intake Form - Youth

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.

Legal Name of Client: _____ Today's Date _____

Preferred Name of Client: _____

Preferred Pronouns: _____

DOB _____ Age _____ Gender _____

Cell Phone# _____ Accepts Text (yes/no) _____

Name of legal guardian completing the form _____ _____

Address _____ City _____ State _____ Zip _____

Home # _____ Work # _____ Cell phone # _____

Emergency Contact:
Name: _____ Phone: _____

Emergency Contact Relationship: _____

Communication Preference:

- ☐ Phone
- ☐ Email
- ☐ Can we leave voicemail?
- ☐ Text
- ☐ Which phone number do you prefer:

How did you hear about The Production Farm (TPF)

- ☐ Church/Religious Affiliation
- ☐ United Way's 2-1-1
- ☐ County Department of Social Services/Health Services/Human Services
- ☐ Insurance Company
- ☐ Department of Corrections / Legal System / Court
- ☐ Internet Search
- ☐ Employee Assistance Program (EAP)
- ☐ TPF Client

- [ ] Employer / Co-worker
- [ ] Facebook / Twitter
- [ ] Friend / Relative
- [ ] Hospital / Doctor / Mental Health Provider
- [ ] School
- [ ] TPF Employee / TPF Program
- [ ] TPF Website / Brochure
- [ ] Other Social Service Agency
- [ ] Phone Book
- [ ] Self - Returning TPF Client
- [ ] Other:

If you are filling out for a child, please answer the following questions from the client's perspective. If you are the client, please answer to the best of your ability.

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:

_____

Are you currently being seen by another mental health therapist or substance abuse therapist? ☐ Yes ☐ No If yes, who? _____

It is often advantageous for all your behavioral health clinicians to have the ability to collaborate / communicate.

Do you consent to allow this collaboration? ☐ Yes ☐ No

Have you ever been a victim of a crime? (whether reported or not) *Some examples might include: Sexual or physical abuse, bullying, etc.)*

☐ Yes ☐ No

If yes, please explain?

_____

Were you adopted? ☐ Yes ☐ No Who lived with you growing up?: _____

Did you have step parents growing up? ☐ Yes ☐ No

How would you describe your family growing up?

_____

What is your relationship with your mother?:

What is your relationship with your father?:

What is your relationship with your primary caregiver?:

Did you experience any physical, emotional, or sexual abuse or neglect as a child or as an adult?

☐ Yes ☐ No Describe: _____

What is your relationship status: (Check all that apply)

☐ Single ☐ Married ☐ Dating ☐ Cohabitating

☐ Divorced ☐ Seperated ☐ Other:

Checklist of Concerns

☐ Abuse - physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals

☐ Aggression, violence

☐ Alcohol use

☐ Anger, hostility, arguing, irritability

☐ Anxiety, nervousness

☐ Attention, concentration, distractibility

☐ Career concerns, goals, and choices

☐ Childhood issues (your own childhood)

☐ Codependence

☐ Confusion

☐ Compulsions

☐ Custody of children

☐ Decision making, indecision, mixed feelings, putting off decisions

☐ Delusions (false ideas)

☐ Dependence

☐ Depression, low mood, sadness, crying

☐ Headaches, other kinds of pains

☐ Health, illness, medical concerns, physical problems

☐ Housework / chores -- quality, schedules, sharing duties

☐ Inferiority feelings

☐ Interpersonal conflicts

☐ Impulsiveness, loss of control, outbursts

☐ Irresponsibilities

☐ Judgment problems, risk-taking

☐ Legal matters, charges, suits

☐ Loneliness

☐ Marital conflict, distance / coldness, infidelity / affairs, remarriage, different expectations, disappointments

☐ Memory problems

☐ Menstrual problems, PMS, menopause

☐ Mood swings

☐ Motivation, laziness

☐ Nervousness, tension

- [ ] Divorce, separation
- [ ] Drug use - prescription medications, over-the-counter medications, street drugs
- [ ] Eating problems - overeating, undereating, appetite, vomiting (see also 'weight and diet issues')
- [ ] Emptiness
- [ ] Failure
- [ ] Fatigue, tiredness, low energy
- [ ] Fears, phobias
- [ ] Friendships
- [ ] Gambling
- [ ] Grieving, mourning, deaths, losses, divorce
- [ ] Guilt
- [ ] Sexual issues, dysfunctions, conflicts, desire differences, other (see also 'abuse')
- [ ] Shyness, oversensitivity to criticism
- [ ] Sleep problems - too much, too little, insomnia, nightmares
- [ ] Smoking and tobacco use
- [ ] Spiritual, religious, moral, ethical issues
- [ ] Stress, relaxation, stress management, stress disorders, tension
- [ ] Suspiciousness
- [ ] Obsessions, compulsions (thoughts or actions that repeat themselves)
- [ ] Oversensitivity to rejection
- [ ] Panic or anxiety attacks
- [ ] Parenting, child management, single parenthood
- [ ] Perfectionism
- [ ] Pessimism
- [ ] Procrastination, work inhibitions, laziness
- [ ] School problems (see also ' career concerns')
- [ ] Self-centeredness
- [ ] Self-esteem
- [ ] Self-neglect, poor self-care
- [ ] Suicidal thoughts
- [ ] Temper problems, self-control, low frustration tolerance
- [ ] Thought disorganization and confusion
- [ ] Threats, violence
- [ ] Weight and diet issues
- [ ] Withdrawal, isolating
- [ ] Work problems, employment, workaholism / overworking, can't keep a job, dissatisfaction, ambition

Any other concerns or issues:

Psychosocial History

Treatment History

Have you ever participated in counseling, psychotherapy, psychiatric/mental health treatment, or substance abuse treatment? If so, please complete the following information to the best of your ability:

Dates(s)	Provider	Purpose / Focus of Treatment	Outcome

Trauma History

Did you experience any physical, sexual, or emotional / physiological abuse or neglect during childhood or as an adult? If so, please describe:

Have you had any experiences you'd consider to be traumatic (e.g., threat of serious harm / injury, natural disaster, victim of a crime, etc.)? If so, please describe:

Have you ever experienced a significant loss? (e.g., loss of parent, child, animal, etc.)

Medical Conditions & History

Do you have any current or recent medical / physical concerns?

☐ Yes ☐ No Describe:

Do you have a primary care physician?

☐ Yes ☐ No Name and location:

Do you have health insurance? ☐ Yes ☐ No

Please describe any history of surgeries, significant medical procedures, or ER visits, or major illnesses (including dates if possible):

Medications (including dosages, prescribing physician, and purpose of medication):

Allergies:

Substance Use

Please enter the following information for any substances including alcohol, tobacco, and drugs that you currently use or have used in the past:

Substance	Past use? (Yes / No)	Current Use? (Yes / No)	How often / how much in the past year?

Social, Spiritual, & Developmental History

Where were you born?

Where did you live growing up?

Were their complications with your birth?

Were there any developmental delays growing up?

What were your friendships like growing up?

Describe your friendships now?

Who do you turn to for support?

How many serious relationships have you been in your life?

Describe your history of romantic relationships? _____

Are you in a relationship now? ☐ Yes ☐ No If yes, for how long? _____

Describe your relationship with your significant other: _____

Describe your sexual orientation: (Check all that apply)

☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Pansexual

☐ Questioning ☐ Asexual ☐ Other:

Describe your religious or spiritual beliefs::

_____

Describe any social groups or institutions you are involved in (e.g., clubs, associations, congregations)::

_____

What do you do on your spare time?:

_____

Educational and Vocational History

What was school like for you growing up?

_____

What is the highest level of education / highest grade you completed?:

_____

If you went to college or grade school, what degrees or certifications did you earn?:

_____

Describe your employment history.:

_____

Are you working now? ☐ Yes ☐ No

What is your occupation? _____ Annual income: _____

How many jobs have you had in the last 6 months.:

Describe any vocational / occupational goals you may have for the future.:

Legal History

Have you ever been arrested? ☐ Yes ☐ No

If so, when and what charge(s)?.:

Describe any current legal concerns.:

Family Information

1. Does the child live with the parent(s)? ☐ Yes ☐ No
2. If no, where does the child live and with whom? (Names / Relationships):
3. Has the child lived with anyone else in the past? ☐ Yes ☐ No
4. If yes, with whom and where?:
5. Has the child lived anywhere outside the home (lived with grandma in summers, crash at friends houses multiple times per week, etc)? ☐ Yes ☐ No
6. If yes, with whom and where?:
7. Who has legal guardianship of the child? _____
8. Parent / Guardian 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 _____

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 _____ Phone _____

Address _____ DOB _____ Age _____

Occupation _____ Education _____

Please provide information about the child's brother(s) and sister(s) and any other children living in the home:

☐ Yes ☐ No

Please provide information about the children and any other children living in the home with the client:

Name	Gender		DOB	Relationship (Biological, Half, Step, Foster, Respite)
	M	F		
	M	F		
	M	F		
	M	F		

	M	F		

If your biological child(ren) does not live with you, where does the child(ren) live?

Any other comments?

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

Has anyone in your family ever been diagnosed or treated for a mental health disorder or for an alcohol - or drug-related problem? Has anyone had these problems but not been treated? If either any of the following apply, please indicate below:

Eating disorders	Mental Illness	Suicide (attempts or actual)	Physical Abuse
Sexual abuse	Emotional Abuse	Domestic Violence	Custody Issues
Incarceration	Gambling	Sexual Addiction	Spending issues
Substance abuse			

Family Member	Problem / Disorder	Describe Treatment (if any)

The family's strengths are:

The family's weaknesses are:

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

Billing Information

Payment Method:

- ☐ Insurance
- ☐ Medical Assistance
- ☐ Self Pay

Insurance Name: _____

Phone number on card: _____

Subscriber's Name: _____

Subscriber's Address: _____

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

Identification Number: _____

Address to Mail Claims: _____

Person responsible for Billing (If different from client):

Name _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Relationship to client: _____

Discounted / Sliding Fee Application and Agreement

It is the policy of The Production Farm 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 $____ and ongoing services are billed at a rate of $____ per service 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 the 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.*

# Living in Household:	Household Income	
Self (income)		Yearly / Monthly / Bi-Weekly (circle which one)
Other Adult (s) (Income)		Yearly / Monthly / Bi-Weekly (circle which one)
Dependent Children under age 18		Yearly / Monthly / Bi-Weekly (circle which one)
Total:		Yearly / Monthly / Bi-Weekly

		(circle which one)

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 The Production Farm to release any information necessary to process insurance claims to:

_____

If requested, I am entitled to list the 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 Signature: _____ Date: _____

Legal Guardian's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____

BILL OF RIGHTS FOR MENTAL HEALTH SERVICES
At The Production Farm

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 prescribing physicians.**
8. **You may not be subjected to any treatment measure that lacks evidentiary validity 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 client 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 Production Farm Privacy Notice".

Client Signature: _____ Date: _____

Legal Guardian's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____

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 The Production Farm according to the agreed upon treatment plan.

Client Signature: _____ Date: _____

Legal Guardian's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____

Your Health Information Rights

You Have The Right To:

See or Copy Your Health Information — You have the right to see or copy your health information. You have a right to request that copy be provided in electronic form or format. If the form and format are not easily created, then we will work with you to provide it in a reasonable electronic form or format. We may charge you a reasonable fee for costs associated with your request.

Correct Information You Believe to be Incorrect or Incomplete — If you believe that your medical information is incorrect or incomplete, you may submit a request to us asking that your information be changed. Your request must be in writing and must include the reason(s) why you believe a change should be made. We are not required to approve your request. We will notify you if we approve your request, or explain the reason(s) for our decision if we deny your request.

Request a Listing of Who was Given Your Information and Why — You have the right to request a list of disclosures of your medical information that we made in compliance with federal and state law. Upon your request, we will provide you with a list that includes the date we released medical information, the name of the person or organization, a brief description, and the reason for the disclosure. We will provide one list free of charge per year.

Request Restriction(s) on How We Use or share your Information —You have the right to request a restriction or limitation on how we use or release your medical information for purposes of treatment, payment, or operations. We may choose not to comply with a restriction request, unless you or another person have paid for services out-of-pocket, in full, and you request that we do not disclose medical information related solely to those services to a health plan. We ask that you complete a request form from the treatment location site's Privacy Officer and/or designee and submit it for evaluation. We will contact you if we deny your request.

Request Confidential Communication(s) — You may ask that we communicate with you about health matters in a certain way or at a certain location. For example, if you are an outpatient client, you could request that we contact you at your workplace or via email. We will attempt to accommodate all reasonable requests. To request an alternative method of communication, you must specify how or where you wish to be contacted.

Request a Paper Copy of this Notice —You have the right to request a paper copy of this Notice from us at any time. Please contact the facility you received services or treatment from to request a paper copy. You may also view and download a copy of this Notice from our web site. The address is: http://www.dhs.wisconsin.gov

Notified of a Breach — *Your provider is required by law to maintain the privacy of your information and provide you with notice of its legal duties and privacy practices with respect to your information and notify you following a breach of unsecured protected health information.*

How Your Health Care Information May Be Used Without Your Written Permission

Your medical information may be used and released by us for purposes of treatment, payment for services, administrative and operational purposes, and to evaluate the quality of the services that you receive. Because we provide a wide range and variety of health care and social services to the people in Wisconsin, not all types of uses and releases can be described in this document. We have listed some common examples of permitted uses and releases below.

For Treatment — We may share your medical information when we coordinate services you may need, such as hospitalization, or follow-up care. For example, your medical information may be given to a pharmacist when you need a prescription filled.

For Payment — We may release your medical information for billing purposes to collect payment for service and treatment that you receive. For example, your medical information may be shared with your health plan to provide billing information for services that you have received. We may also share your medical information with government programs such as Workers' Compensation, Medicaid, Medicare or the Indian Health Services to coordinate benefits and payment.

For Health Care Operations — We may use and release your medical information to ensure that the services and benefits provided to you are appropriate and high quality. For example, we may use your medical information to evaluate our treatment and service programs or to evaluate the services of other providers that use government funds to provide health care services to you. We may combine medical information about many individuals to research health trends, to determine what services and programs should be offered, or whether new treatments or services are useful.

Health Information Exchange — We may make your medical information available electronically through an information exchange service to other health care providers, health plans, and health care clearinghouses that request your information. Participation in information exchange services also lets us see their information about you.

To Other Government Agencies Providing Benefits or Services — We may release your medical information to government agencies or programs that provide similar services or benefits to you if the release is necessary to coordinate the delivery of your services or benefits, or improves our ability to administer or manage the program.

For Public Health — We may release your medical information to local, state, or federal public health agencies, subject to the provisions of applicable state and federal law. For example, we may disclose information for the following types of activities:

- To prevent or control disease, injury or disability or to keep vital statistics records such as data about births and deaths;
- To notify social service agencies that are authorized by law to receive reports of abuse, neglect or domestic violence, and;
- To report reactions to medications or problems with products to the Federal Food and Drug Administration.

For Health Oversight — We may share your medical information with other divisions of the Department of Health Services and with other agencies for oversight activities as required by law. Examples of these oversight activities include audits, inspections, investigations, and licensing activities.

Law Enforcement — Your medical information may be disclosed to fulfill a requirement by law or law enforcement agencies. For example, medical information may be used to identify or locate a missing person.

Court or Other Hearings — Your medical information may be disclosed to comply with a court order.

For Research — We may release your medical information for research projects that have been reviewed and approved by an institutional review board or privacy board to ensure the continued privacy and protection of the medical information.

For Lawsuits and Disputes — If you are involved in a lawsuit or dispute, we may release your medical information about you in response to a legal order. We may also release your medical information in response to a subpoena, discovery request, or other lawful process by another party involved in the dispute, but only if they have made an effort to tell you about the request or to obtain an order protecting the medical information requested.

To Coroners, Medical Examiners and Funeral Directors — We may release your medical information to a coroner, medical examiner, or funeral director, as necessary to carry out their duties as authorized by law. For example, release of medical information may be necessary to identify a deceased person.

For Organ Donations — If you are an organ donor, we may release your medical information to an organization that procures, banks, or transports organs for the purpose of an organ, eye, or tissue donation and transplantation.

To Avert A Serious Threat to Health or Public Safety — We may release your medical information if it is necessary to prevent or lessen a serious threat to your health and safety, the health and safety of another person, or to the general public.

For National Security and Protection of the President — We may release your medical information to an authorized federal official or other authorized person for the purpose of national security, providing protection to the President, or to conduct special investigations as authorized by law.

To Correctional Institutions — If you are an inmate of a correctional institution or in the custody of a law enforcement officer, we may release your medical information to the correctional institution or law enforcement officer, provided the release is necessary to provide you with health care, protect your health and safety, the health and safety of others, or for the safety and security of the correctional institution.

Specialized Government Functions — We may release your medical information to the government for specialized government functions. For example, your medical information may be disclosed to the Department of Veterans Affairs to determine eligibility for benefits.

If you do not object and the situation is not an emergency and disclosure is not otherwise prohibited by other laws, we are permitted to release your information under the following circumstances:

- To Individuals Involved In Your Care **—** We may release your medical information to a family member, other relative, friend or other person whom you have identified to be involved in your health care or the payment of your health care;

- To Family **—** We may use your medical information to notify a family member, a personal representative or a person responsible for your care, of your location, general condition or death, and;

- To Disaster Relief Agencies — We may release your medical information to an agency authorized by law to assist in disaster relief activities.

Required by Law — In addition to the ways listed previously, your medical information may be disclosed when required by law.

Applicability of More Stringent State Law — Some of the uses and disclosures described in this notice may be limited in certain cases by applicable state laws that are more stringent than federal laws, including disclosures related to mental health and substance abuse, developmental disability, alcohol and other drug abuse (AODA), and HIV testing.

Our Responsibilities

We are required by state and federal law to maintain the privacy of your medical information. Release of your medical information for reasons other than those necessary for treatment, payment or operations, as outlined in this Notice, or as otherwise permitted by state or federal law, will be made **only** with your written authorization. You may revoke, in writing, your authorization at any time. If you revoke your authorization, we will no longer release your medical information to the prior authorized recipient(s), except to the extent that we previously relied on your original authorization to release your information.

We are required to abide by the provisions of this Notice. We, however, reserve the right to revise this Notice. We also reserve the right to make the revised Notice effective for the medical information that we maintain. We will post a current copy of this Notice at our treatment sites and on our website. In addition, you may ask for a copy of our current privacy practices whenever you visit one of our facilities for treatment or to receive health care services.

For More Information or to Report a Problem

Please send your written complaints about this Notice, how we handle your medical information, or if you believe your privacy rights have been violated to the facility you believe the violation occurred.