Program : ___ Child PHP___ Adolescent PHP___ Adolescent PHP___ Adult PHP____ Adult IOP
Date: _____ MR# _____ For Office Use Only

BEHAVIORAL HEALTH SERVICES PATIENT REGISTRATION

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: M F
Street Address : _____
Street City State Zip Code County
Patient's Primary Contact Phone #: _____ Ok to call/leave message __Yes __No
Patient's Primary Email Address: _____

PARENT INFORMATION/EMERGENCY CONTACT

Name: _____ Relationship: _____
Address (if different): _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____
Address (if different): _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Care Physician: _____ Phone: _____ Fax: _____
Address: _____
Psychiatric Prescriber: _____ Phone: _____ Fax: _____
Address: _____
Outpatient Therapist: _____ Phone: _____ Fax: _____
Address: _____
Pharmacy: _____ Phone: _____ Fax: _____
Address: _____

INSURANCE INFORMATION

Primary Insurance : _____ Policy # _____ Group# _____
Insurance Company Phone #: _____
Subscriber's Name: _____ DOB: _____
Subscriber's Employer: _____ Relationship to Patient: _____
Subscriber's Address: (if different from patient): _____
Secondary Insurance : _____ Policy # _____ Group# _____
Insurance Company Phone #: _____
Subscriber's Name: _____ DOB: _____
Subscriber's Employer: _____ Relationship to Patient: _____
Subscriber's Address: (if different from patient): _____

_____ _____ _____
Patient Signature (if 18 or older) Printed Name Date

_____ _____ _____
Parent/Guardian Signature Printed Name Date

Rev.7/9/22

Four Winds HOSPITALS **DOCUMENT SIGNATURE PAGE** **CONSENT FOR TREATMENT**	Patient Name: Date of Birth:

I am requesting voluntary admission to the Partial Hospital Program and/or Intensive Outpatient. I understand that as a voluntary patient, I can choose to discontinue the program at any time for any reason. However, program staff strongly encourages patients to discuss their intention to leave the program prior to making the final decision. I have received a Patient Guide, which includes patient rights and responsibilities, as well as the programs grievance procedure. I understand that I may go to any clinical staff member if I have questions or concerns about any of my rights or responsibilities. The risks and benefits of the Program have been fully explained to me and I am choosing to participate in the program, being fully aware of these risks and benefits.

Additionally, the prescribing of over the counter medications may occur which will allow for the administration of medications that treat symptoms such as minor aches and pain, stomach upset, cold symptoms or other minor physical complaints. All other medications which are recommended for my / my child's treatment will be reviewed with me prior to the prescribing of such medication.

☐ Yes, I consent to over-the-counter medications ☐ No, I do not consent to over the counter medications

I have received a copy of the following documents (check all documents given to the patient):

- ☒ Bills Of Rights
- ☒ Notice of Privacy Practices
- ☒ Patient Guide
- ☐ An Important Message from Medicare

Patient Signature:	**Date:**
Parent or Legal Guardian:	**Date:**

I hereby consent to the taking of my photograph for identification purposes only. I understand that, upon discharge, my photograph will be kept by Four Winds Saratoga and filed in my medical record.

Patient Signature:	**Date:**
Parent or Legal Guardian:	**Date:**

I have discussed the above with the patient and his/her family (when available) and he/she has indicated an understanding of the rights guaranteed to him/her while a patient at Four Winds Saratoga.

Patient refuses to discuss above (check if applicable)	☐ Yes	☐ No
Patient refused handouts (check if applicable)	☐ Yes	☐ No

Staff Signature:	**Date/time:**

Four Winds HOSPITALS

FAMILY MEDICAL QUESTIONNAIRE
ONGOING MEDICAL PROBLEMS

Patient's Name:

Patient's Date of Birth:

Name of Your/Your Child's Primary Medical Provider:	**Phone Number:**
Date of Last Visit to Your/Your Child's Primary Medical Provider:	**Reason for this Visit:**

HAVE YOU/YOUR CHILD EVER HAD:			**Comments**
Chicken Pox Illness	☐ Yes	☐ No	
Chicken Pox Vaccine	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No	
Allergies	☐ Yes	☐ No	
High Blood Pressure	☐ Yes	☐ No	
Heart Condition or Murmur	☐ Yes	☐ No	
Head Injury	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Seizures/Convulsions	☐ Yes	☐ No	
Tuberculosis or Positive Skin Test	☐ Yes	☐ No	
Undescended Testicles	☐ Yes	☐ No	
Last Menstrual Period/Age at 1st Period	☐ Yes	☐ No	
Eye/Ear/or Speech Problem	☐ Yes	☐ No	

List Any Surgeries or Hospitalizations You/Your Child Has Had:

CHECK AND EXPLAIN ANY OF THE FOLLOWING CURRENT OR ONGOING PROBLEMS:			
Weight Loss	☐ Yes	☐ No	
Weight Gain	☐ Yes	☐ No	
Sore Throat	☐ Yes	☐ No	
Frequent Headaches	☐ Yes	☐ No	
Skin Rashes/Eczema	☐ Yes	☐ No	
Difficulty Breathing	☐ Yes	☐ No	
Cough	☐ Yes	☐ No	
Sinus Problems	☐ Yes	☐ No	
Diarrhea	☐ Yes	☐ No	
Constipation	☐ Yes	☐ No	
Vomiting	☐ Yes	☐ No	
Problems with Urination	☐ Yes	☐ No	
Bedwetting	☐ Yes	☐ No	
Joint Problems or Pain	☐ Yes	☐ No	

OTHER:

Please continue on to the back of the form.

DEVELOPMENTAL HISTORY (Only for patients under age 18)

	YES	NO
1. Were there problems in pregnancy, labor, or delivery?	☐	☐
If yes, what happened?		
2. Did the mother use ☐ cigarettes, ☐ drugs or ☐ alcohol during pregnancy?	☐	☐
3. Did your child experiences any problems during the first year?	☐	☐
If yes, please describe.		
4. Do you believe your child's development was normal?	☐	☐
If no, why?		

5. At what age did your child first walk? At what age did your child first use words correctly?

MEDICATIONS/ALLERGIES

6. What medication(s) are You/Your Child currently taking?

7. Are You/Your Child allergic to anything? Yes ☐ No ☐

If yes, what?

MEDICAL HISTORY

8. Do you believe You/Your Child is healthy? Yes ☐ No ☐

If no, why?

9. Are You/Your Child's immunizations (shots) up-to-date? Yes ☐ No ☐
Do You/Your Child attend school in NYS? Yes ☐ No ☐ N/A ☐

10. Have you/your child ever been hospitalized overnight or longer? Yes ☐ No ☐

If yes, when and for what reason?

11. Your/Your Child's dentist is:	12. Date of last dental check-up:

TB RISK FACTOR SCREENING

1) Any history of foreign of birth or travel greater than a three month stay in a country with higher risk of TB than the USA?	☐ Yes	☐ No	If so, which country or countries:
2) Any history of close contact with a person diagnosed with active TB?	☐ Yes	☐ No	Relationship: When:
3) Any current symptoms of TB (i.e., cough greater than two weeks, unexplained weight loss, night sweats or bloody sputum).	☐ Yes	☐ No	If yes, give details:

Signature:	Relationship to Patient:		Date:
Physician/NPP/FNP Signature:	Title:	Date:	Time:

FOR CLINIC USE ONLY

Date:_____

Time:_____ AM/PM

Reviewed by:_____

Financial Agreement and Guarantee

Please Print Date_____

Patient Name_____ Medical Record No._____

Parent's Name _____Parent's Name _____

Other Responsible Party (state relationship)_____

ASSIGNMENT OF BENEFITS

I hereby assign to Four Winds Hospitals all my right, title and interest, including benefit of payment to which I am or may be entitled from _____ insurance company under policy 1 #_____ for Insured Name_____ and from _____ insurance company under policy 2 #_____ for Insured Name_____ or from any governmental agency, other insurance carrier and/or their agents, or others who are financially responsible for the hospitalization and medical care and services rendered to me or my dependent at Four Winds Hospitals.

FINANCIAL AGREEMENT AND GUARANTEE

(I)We (jointly and severally) agree to pay and guarantee payment to Four Winds Hospitals the full and entire amount of any and all bills not paid in full by our health insurance plan(s), private or governmental, or combination of plans due to any reason including, without limitation, exhaustion of benefits, a pre-existing condition excluded from coverage, and responsibility for co-payments. I understand that all such bills are due and payable upon presentation at the Hospital's negotiated rate with my health insurance plan(s), or if I do not have health insurance benefits, at the rate I have negotiated with the Hospital. Payment may be demanded at any time from any of the undersigned, and failure to demand payment of the patient shall not be a prerequisite to the guarantor's immediate responsibility for payment. This agreement shall be governed by the laws of the State of New York as a contract deemed executed in New York and to be performed in New York. We expressly consent to the jurisdiction of New York State and federal courts and to venue in Westchester County in any action brought relating to this agreement. We agree to pay any costs and expenses incurred by Four Winds Hospitals to enforce this agreement, including reasonable attorneys' fees. This document constitutes the complete agreement of the parties. We acknowledge that we have not relied on statements, promises, or representations, oral or written, other than as contained herein. Four Winds Hospitals has accepted my check or cash for such amount and provided me with a receipt. Any amounts charged or paid in excess of what is owed will be refunded within 7 to 10 business days.

Four Winds Financial Agreement and Guarantee (continued)

Patient Name_____ Med. Rec. No._____

RESPONSIBILITY FOR SPECIALIZED SERVICES

(I)We understand that psychiatric and basic medical care is provided by Four Winds Hospitals. However, if specialized medical services not provided at Four Winds are indicated, we agree that the cost of such medical consultation/treatment will be (my)our responsibility. Whenever possible, Four Winds will notify the family or financially responsible person that such specialized care is indicated in advance of the visit to the medical consultant.

DENIAL OF PAYMENT BY THIRD PARTY PAYOR

Four Winds Hospitals has accepted my check or cash for 7 days of hospitalization and provided me with a receipt. **My check will be held until there is a denial of payment.** Any amounts charged or paid in excess of what is owed will be refunded within 7 to 10 business days. A small number of health plans provide that beneficiaries sign an addendum to this financial obligation form at the time of a denial based on lack of medical necessity. (I)we understand that (I)we will be notified by phone or in person of the denial by Four Winds Hospitals staff at the time that the Hospital is notified. If provided by my health plan, I agree to promptly execute an addendum.

If I(we) fail to execute such addendum and (I)we elect to continue to receive services at Four Winds Hospitals, (I)we agree to promptly pay for such uncovered services.

ALL PARTIES MUST SIGN

WE HAVE READ AND UNDERSTOOD THIS AGREEMENT AND ATTEST THAT ALL INFORMATION IS TRUE, COMPLETE, AND ACCURATE.

_____
Patient (if 18 or over)

_____
Parent

_____
Parent

_____
Spouse

_____
Other Responsible Party (state relationship to patient)

INSTRUCTIONS FOR COMPLETING THE ATTACHED RELEASES

Attached are RELEASE OF INFORMATION FORMS. Please complete one page for any of the following that pertain to you / your child:

1. Your Medical Dr. (PCP)
2. Your Therapist
3. Your Medication Prescriber
4. Your Insurance Company – check both boxes marked "other" and specify "BILLING". The name of insurance company goes on top under agency

PLEASE MAKE SURE RELEASES ARE FILLED OUT WITH PROVIDERS FULL NAME – COMPLETE ADDRESS- FAX AND PHONE NUMBER.

THANK YOU

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME:

DATE OF BIRTH:

FOUR WINDS HOSPITALS

Please forward the request to the location you wish to obtain from/release to:

Westchester
800 Cross River Road
Katonah, NY 10536
Phone: (914) 763-8151
Fax: (914) 763-0950

Saratoga
30 Crescent Avenue
Saratoga Springs, NY 12866
Phone: (518) 584-3600
Inpatient Fax: (518) 580-1514
Partial Fax (518) 581-2535

I authorize Four Winds Hospitals to obtain from and/or release to:

Person/Agency/School:

Address:

City, State, Zip:

Phone: Fax:

Covers the period of healthcare: ☐Most recent hospital admission ☐Last 1 year ☐All hospital admissions

Or ☐From Date: _____ To Date: _____

Unless a period is specified, the information below will be provided from the most recent hospital location admission only

The Specific Information to be Disclosed is:

- ☐ Diagnosis Only
- ☐ Dates of admission and/or discharge
- ☐ Integrated Assessments/Psychiatric Assessment
- ☐ Discharge Summary
- ☐ Verbal/Written Communication for Discharge
- ☐ Psychological Testing
- ☐ Psychosocial Assessment
- ☐ Medical: H&P, Labs, EKG, other Medical Information
- ☐ Applications
- ☐ Progress Notes
- ☐ Educational Summary / Materials / Verbal Academic Reports
- ☐ HIV-related information, if applicable
- ☐ Entire Medical Record
- ☐ Other (specify):_____

This information will be used for the following purpose(s):

- ☐ Evaluation and Continuing Treatment / Coordinating Care
- ☐ Educational Placement / Other Educational Concerns / Billing School District for Education
- ☐ Legal / Custody / Court / Probation
- ☐ Other (specify):_____

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I understand that I have the right to revoke this authorization at any time, by submitting a revocation in writing to the Medical Records Department. The revocation will not apply to information that has already been released in response to this authorization. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire in one year from the date of the signature below and may be used until such time for either a one-time release or periodic release of information.

If the disclosure is for educational purposes, I understand that the recipient may be my child's home school district, any school within the home school district, and a school that my child attends which is funded by the home school district. Disclosure to any other school or educational entity requires a separate authorization.

I understand that authorizing the disclosure of this information is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I have a right to receive a copy of this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient, and the information may not be protected by the federal privacy rules or by New York law.

If I am authorizing the release of HIV-related information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

If Signed by Legal Guardian, Relationship to Patient	Date

Signature of Patient or Legal Guardian	Signature of Staff Person Releasing Information	
	Title	Date Released

Four Winds HOSPITALS

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Address:

City, State, Zip:

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Four Winds HOSPITALS

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Four Winds Hospitals is a two hospital system comprised of both Four Winds Westchester and Saratoga inpatient hospitals, partial hospitalization programs, and intensive outpatient programs. I understand authorizing this disclosure applies to both hospitals at every level of care. I understand that a separate authorization form is not needed to exchange protected health information between both hospitals at every level of care for the purposes of treatment, payment, and operations.

I understand that I have the right to revoke this authorization at any time, by submitting a revocation in writing to the Medical Records Department. The revocation will not apply to information that has already been released in response to this authorization. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire in one year from the date of the signature below and may be used until such time for either a one-time release or periodic release of information.

If the disclosure is for educational purposes, I understand that the recipient may be my child's home school district, any school within the home school district, and a school that my child attends which is funded by the home school district. Disclosure to any other school or educational entity requires a separate authorization.

I understand that authorizing the disclosure of this information is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I have a right to receive a copy of this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient, and the information may not be protected by the federal privacy rules or by New York law.

If I am authorizing the release of HIV-related information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

If Signed by Legal Guardian, Relationship to Patient	Date

Signature of Patient or Legal Guardian	Signature of Staff Person Releasing Information	
	Title	Date Released

Four Winds HOSPITALS

JONATHAN'S LAW CONTACT SHEET

For Inpatients and Outpatients: Clinical staff completes at the time of screening or admission. If the patient is the qualified person, complete Section A only. If the patient is not the qualified person, complete Section B.

SECTION A (Complete if the patient is the qualified person.)

- ☐ Patient received Jonathan's Law Information Sheet.
- ☐ Reviewed Jonathan's Law with the patient and (check one):
  - ☐ Patient verbalized an understanding of the above and had an opportunity to ask questions.
  - ☐ Patient not able to participate in above.

Patient's Signature:		Date:
Staff Signature:	Title:	Date:

SECTION B (Complete if the patient is not the qualified person.)

- ☐ Patient/qualified person received Jonathan's Law Information Sheet.
- ☐ Reviewed Jonathan's Law with the patient and qualified person and (check one):
  - ☐ Patient/qualified person verbalized an understanding of the above and had a opportunity to ask questions.
  - ☐ Patient/qualified person refused to participate in above.

The qualified person was asked if he/she wanted to be notified of incidents (complete one):

- ☐ Yes. Complete the following and remind the qualified person to provide updates to telephone numbers should the information change in the future.

Name of Qualified Person:

Address:	
Phone Number:	Phone Number:

- ☐ No. The qualified person indicates that he/she does not wish to be notified of incidents.

Qualified Person Signature:		Date:
Staff Signature:	Title:	Date:

Four Winds SARATOGA
a psychiatric health system

MEDICAL EMERGENCY CONSENT

		DATE OF ADMISSION
PATIENT'S NAME	AGE	DATE OF BIRTH
(MOTHER/GUARDIAN) FOR MINOR PATIENT	(FATHER / GUARDIAN) FOR MINOR PATIENT	
PATIENT / PARENT / GUARDIAN ADDRESS		
PATIENT / PARENT / GUARDIAN TELEPHONE (HOME)	BUSINESS	
PATIENT'S PHYSICIAN	MD TELEPHONE	
ADDRESS		

EMERGENCY INFORMATION

KNOWN ALLERGIES

CURRENT MEDICATIONS

DATE OF LAST TETANUS BOOSTER

AUTHORIZATION

1. I authorize Four Winds Saratoga to provide emergency treatment to _____ and to provide emergency room transportation to Saratoga Hospital.
2. I authorize Saratoga Hospital to provide emergency room treatment to _____.
3. I authorize Saratoga Hospital/Saratoga Care Wilton Medical Arts to exchange information with Four Winds Saratoga to coordinate my care and exchange information relating to my care at both facilities. This release will expire 10 days after I have been discharged from Four Winds Saratoga, unless I request differently.

I understand that in the event of any emergency situation Four winds Saratoga will make all attempts to notify the following person(s) and the above stated physician. In the event I am not able to authorize the hospital to notify the following person(s), I authorize Four Winds Saratoga to notify the following persons:

NAME	Phone (AM)	(PM)
ADDRESS		
RELATIONSHIP TO PATIENT		
NAME	Phone (AM)	(PM)
ADDRESS		
RELATIONSHIP TO PATIENT		

SIGNATURE OF PATIENT, PARENT OR GUARDIAN: _____ DATE: _____

WITNESS / TITLE: _____ DATE: _____

Four Winds Saratoga

MEDICATION QUESTIONNAIRE

Name:

Date: Date of Birth:

DIRECTIONS: Please place a check mark in the box that describes your experience with any of the medications listed below.

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	Patient, Parent, Guardian or Physician/NPP Comments
ANTIDEPRESSANTS							
Amitriptyline	Elavil						
Brexanolone	Zulresso						
Bupropion	Wellbutrin, Wellbutrin SR, Wellbutrin XL, Aplenzin, Forfivo XL						
Citalopram	Celexa						
Clomipramine	Anafranil						
Desipramine	Norpramin						
Desvenlafaxine	Pristiq						
Doxepin	Sinequan, Silenor						
Duloxetine	Cymbalta						
Escitalopram	Lexapro						
Esketamine	Spravato						
Fluoxetine	Prozac, Sarafem						
Fluvoxamine	Luvox, Luvox CR						
Imipramine	Tofranil						
Isocarboxazid	Marplan						
Levomilnacipran	Fetzima						
Milnacipran	Savella						
Mirtazapine	Remeron, Remeron SolTab						
Nefazodone	Serzone						
Nortriptyline	Pamelor						
Paroxetine	Paxil, Paxil CR						
Phenelzine	Nardil						
Selegiline Transdermal	Emsam						
Sertraline	Zoloft						
Tranylcypromine	Parnate						
Trazodone	Desyrel, Oleptro						
Venlafaxine	Effexor, Effexor XR						
Vilazodone	Viibryd						
Vortioxetine	Trintellix, Brintellix						
ANTIPSYCHOTICS "major tranquilizers"							
Aripiprazole	Abilify, Abilify Maintena, Abilify Mycite, Aristada						
Asenapine	Saphris						
Brexpiprazole	Rexulti						
Cariprazine	Vraylar						
Chlorpromazine	Thorazine						

Four Winds SARATOGA

MEDICATION QUESTIONNAIRE

Name:

Date: Date of Birth:

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	Patient, Parent, Guardian or Physician/NPP Comments
Buprenorphine/ Naloxone	Suboxone, Bunavail, Zubsolv						
Bupropion	Zyban						
Disulfiram	Antabuse						
Methadone	Dolophine						
Naltrexone	ReVia, Vivitrol						
Varenicline	Chantix						
MOOD STABILIZING AGENTS/AED's							
Carbamazepine	Tegretol, Tegretol XR, Carbatrol, Epitol, Equetro						
Fluoxetine/Olanzapine	Symbyax						
Gabapentin	Neurontin						
Lamotrigine	Lamictal, Lamictal XR, Lamictal ODT						
Levetiracetam	Keppra, Keppra XR						
Lithium	Eskalith, Eskalith CR, Lithobid						
Oxcarbazepine	Trileptal						
Pregabalin	Lyrica						
Tiagabine	Gabitril						
Topiramate	Topamax, Trokendi XR, Qudexy XR						
Valproate	Depakene, Depakote, Depakote Sprinkles, Depakote ER, Valproic Acid, Stavzor						
PSYCHOSTIMULANTS							
Amphetamine	Adzenys ER, Adzenys XR-ODT, Dyanavel XR, Evekeo, Evekeo ODT						
Amphetamine Salts (Mixed)	Adderall, Adderall XR, Mydayis						
Armodafinil,	Nuvigil,						
Atomoxetine	Strattera						
Dexmethylphenidate	Focalin, Focalin XR						
Dextroamphetamine	Dexedrine, Dextrostat, ProCentra, Zenzedi						
Lisdexamfetamine	Vyvanse						
Methylphenidate	Ritalin, Ritalin SR, Ritalin LA, Concerta, Metadate ER/CD, Methylin, QuilliChew ER, Quillivant XR, Adhansia XR, Aptensio XR, Cotempla XR-ODT, Jornay PM, Relexxii						
Methylphenidate Transdermal Patch	Daytrana						

Parent/Guardian Social History

Child's Name: _____ Date of Admission: _____ Age: _____

Who resides in your child's home? _____

Who has custody of your child? _____

Caretaker's Name: _____ Relationship to Child: _____

○ *Check here if you are the parent/guardian completing this form*

- Nature of relationship: Excellent - Good - Fair - Poor (circle one)
- The best part of this relationship is: _____

  _____
- When there is a problem, it is usually about: _____

  _____

Caretaker's Name: _____ Relationship to Child: _____

○ *Check here if you are the parent/guardian completing this form*

- Nature of relationship: Excellent - Good - Fair - Poor (circle one)
- The best part of this relationship is: _____

  _____
- When there is a problem, it is usually about: _____

  _____

Siblings: List name(s), age(s). Circle names of the siblings that live with your child.

- Full siblings: _____

  _____
- Half-siblings: _____

  _____
- Step-siblings: _____

  _____

Describe your child's:

Personality

Social Life

Academic Performance:

Hobbies/Interests

Strengths

Weaknesses

What are your primary concerns related to your child's admission? What would you like to see improved prior to your child returning home?

Has your child been attending outpatient therapy? _____

If yes, when was their last visit? _____

How long have they been in therapy? _____

How often is your child seen by their therapist? _____

Is your child currently on any medications? _____

How are the child's medications administered in the home? _____

Is your child compliant with taking their medication? _____

Are there any guns or firearms in your home? _____

If yes, does your child have access to these? _____

Where and how are the guns/firearms stored? _____