Wentworth & Associates, PC
11111 Hall Road . Suite 303 . Utica, MI 48317
Phone: 586.997.3153 Fax: 586.997.4956
www.wentworthandassociates.com

PRACTICE ORIENTATION AND AGREEMENT
YOUR RIGHTS AND RESPONSIBILITIES AS A CLIENT

* You have the right to receive services from clinicians who adhere to the professional code of ethics of their respective disciplines.
* You have the right to receive services in accordance with Federal and State regulations and accreditation standards governing behavioral health programs.
* You have the right to privacy and confidentiality regarding the service you receive. All information about you and your treatment, whether written or oral, is protected under Federal and State laws, including the HIPAA Privacy Act.
* You have the right to informed consent for services offered to you.
* Your clinician is responsible for all service coordination.
* You have the right to refuse services at any time. You have the right to withdraw your consent to receive services and discontinue services at any time. You have a right to information concerning your treatment/care.
* You have the right to know treatment recommendations and the possible outcomes if you choose not to follow these recommendations.
* You have the responsibility to assist in planning your treatment at every stage.
* You have the right to express any concerns or complaints regarding the services you receive. We encourage you to first contact your clinician to resolve any issues. You may also contact the Rights Advisor, Laura Hitt, Office Manager for assistance. A description of how to register a concern is posted in our lobby and on our website.
* You have the responsibility to be timely for your appointments. Late arrivals may result in rescheduled appointments.
* You have the responsibility to arrive for all scheduled sessions, or to notify us 24 hours in advance if you wish to cancel an appointment. **You may be charged a practice fee, up to $125, for non-cancelled or late cancelled appointments**, when an emergency was not involved, because insurance companies and other third-party payers do not cover missed appointments.
* You are responsible for any fees that may be charged to you at the time of service and, also, for knowing your insurance benefits coverage. We check benefits as a courtesy, but this is not a guarantee of coverage.
* Your case will be closed following 45 days of inactivity, unless other arrangements have been made.
* You have the right to know we may call the police if someone comes to the practice under the influence of drugs or alcohol and tries to leave the practice driving a motor vehicle.
* You have the right to know that no member of our staff is allowed to date or have a personal relationship with current or former clients of the practice.
* You have the right to know that staff and therapists are not allowed to accept gifts from clients of the practice, nor are they permitted to enter into any business relationships of any kind with you.
* You have the responsibility to conduct yourself in a non-disruptive and non-aggressive manner while on the premises. Wentworth &Associates will never use restraints but emergency responders will be called if necessary.
* If we are treating your minor child our policy is to make a concerted effort to engage both parents in the therapeutic process.

Reasons your treatment may be terminated:
- Being under the influence of any illegal substance while on the premises
- Threatening the safety or rights of any client or staff member
- Non-compliance with treatment or an inability of the facility to provide you the care you require

*In all instances, you have the right to a referral for a different treatment option

SERVICES OFFERED
Wentworth and Associates offers an array of mental health services. These services include: individual psychotherapy, group therapy, family therapy, marital therapy, psychological testing, Psychiatric evaluations and medication therapy are also available on site. Your clinician will provide you with a detailed description of the nature of services and expected benefits and potential risks.

All cases will be reviewed by Kristi LeBeau, Clinical Director, and Robert Burnstein, M.D. our Medical Director

CLIENT INPUT
Wentworth and Associates will be asking you for ongoing feedback regarding the quality and effectiveness of services you receive. We will ask you to complete clinical outcome questionnaires and satisfactions surveys periodically. W e w ill also review and/or investigate any com plaints or suggestions you may have (contact Rights Advisor). Your feedback is considered an important part of treatment/care.

OPERATIONS
Office hours are usually between 7AM and 10PM, 7 days a w eek. Not all clinicians are available during all open hours. Appointment dates and times and after hours' contacts shall be arranged between you and your treating clinician. An outdoor elevator is located in the back parking lot of the building for individuals with physical disabilities. In
emergencies, you can contact or go (if able) to the nearest crisis center (Macomb County Crisis Center at 586-307-9100; Oakland Crisis Center at 248-456-0909). You m ay also contact the nearest emergency room. We practice in a non-smoking environment. Illicit drugs and weapons are not allowed on the premises. Persons in possession of either will be asked to leave immediately.

CONFIDENTIALITY
Federal and State laws protect the privacy of communications between a client and a clinician. In most situations, release of information about your services/treatment to others can only be done if you sign a written Authorization to Release that meets certain legal requirements. Also, there are some limits to confidentiality, such as if you intend to harm yourself or others.
Information about privacy and limits to confidentiality will be provided by your primary clinician and is also provided in our Notice of Privacy
Practices. **STATE LAW REQUIRES REPORTING OF SUSPECTED CHILD ABUSE/NEGLECT, ELDER ABUSE.** (attached form and website . www.WENTWORTHANDASSOCIATES.COM).

FINANCIAL RESPONSIBILITY
You are expected to pay for service at the time it is rendered, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. A fee adjustment or a payment installment plan may be negotiated in circumstances of unusual financial hardship. All clients will be informed of payment fee schedules prior to rendering services. Although we are likely to inform you of your insurance deductible and co-pays (if any), you are ultimately responsible for knowing this information and for paying both in full. *A $25 charge may be required for returned checks. You may be charged up to $25.00 if you request records to be sent out. If your client balance exceeds $200.00 service may be suspended, and you will be offered a referral to another clinic where you will be able to continue your treatment.*

If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, legal action may be used to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require disclosure of otherwise confidential information. In most collection situations, the only information released regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its cost will be included in the claim. If I am paying privately, based on my ability to pay, I agree to pay_____ for an Intake Evaluation, _____ for Individual Therapy, _____Family Therapy, _____ for Testing and _____ for Extended Sessions.

MINORS & PARENTS
Clients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. They should also be aware that clients over age 14 can consent to (and control access to information about) their own psychosocial treatment, although that treatment cannot extend beyond 12 sessions or 4 months. While privacy is very important, particularly with teenagers, parental involvement is also essential to successful treatment. Therefore, it is Wentworth and Associates policy to request (but not require) an agreement from any client between 14 and 18 and his/her parents allowing to share general information with parents about the progress of treatment and the child's attendance at scheduled sessions.

CONSENT FOR CASE CONFERENCING

I hereby give my informed consent to have my case presented at case conferencing or group supervision meetings at Wentworth and Associates, PC only.
I understand that my therapist will make every effort to protect my confidentiality and will not be using names or other specific identifying information. I understand that the purpose of presenting my case at these case meetings is to get a multidisciplinary team

approach in order to improve my treatment.
I understand that any clinical staff person or student may attend these meetings and that they are facilitated by the CEO, Dr. Lawrence T. Wentworth, PhD, Licensed Psychologist.
I understand that the staff members are not liable in any way for treatment suggestions, case conceptualizations or recommendations made to my therapist in an effort to improve my care.
I understand that I may revoke my authorization at any time.

Please check one:

I consent to have my case discussed in case conferencing _____
I DO NOT consent to have my case discussed in case conferencing _____

My initials below indicate that I:
_____ Have been made aware of my rights and responsibilities and how to file a grievance or complaint
_____ Have been informed of the name, discipline, and credentials of my primary clinician
_____ Have been informed of practice-specific information and given an orientation to services including fees
_____ Have been informed of privacy practices, confidentiality, and limits to confidentiality
_____ Have been informed of all the emergency evacuation procedures of the practice and its premises.

My signature below indicates that I consent to receive services at Wentworth and Associates, and that I understand I may discuss any questions I have regarding services and that I maintain the option to terminate my consent at any time.

_____ _____
Client Signature Date Client's Name Printed

_____ _____
Signature of Client's Representative Date Wentworth & Associates, PC Staff Signature Date

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Child and Adolescent Background Questionnaire

(Age 17 and under)

Purpose of this questionnaire: The purpose of this questionnaire is to obtain a comprehensive picture of your child/adolescent's background. In psychotherapy, obtaining background information is often necessary, as it permits a more thorough understanding of one's present difficulties. By completing these questions as fully and as accurately as you can, you will facilitate your child/adolescent's therapeutic program. Please answer these questions in your own time, rather than using up your actual consulting time. If there are any questions that you prefer not to answer, merely write, "Do not care to answer."

Please be aware that case records are strictly confidential. **No one outside of the Wentworth & Associates, P.C. staff is permitted to see your child/adolescent's case record without your permission.**

How did you come to be referred to Wentworth & Associates, P.C.? _____
Date: _____ Child's name: _____

Person completing form for this child _____Relationship to child:_____

Phone: Home:_____ Work: _____ Mobile: _____

Address: _____ Email:_____

City, State, Zip: _____

Who does the child reside with? _____

Date of Birth: _____ Sex: _____ Male _____ Female
What is your child's ethnic background? _____

What are your child's religious beliefs, if any? _____

In case of emergency contact:

Name:_____

Phone: (home) _____ (work) _____ (mobile) _____
Address: _____ City/Zip _____

Primary Insurance Company: _____

Effective date: _____ Contract number: _____ Group number:
_____

Full name of subscriber: _____ Relationship: _____ Subscriber's DOB:
_____

Subscriber's place of employment:
_____

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Secondary Insurance Company:
_____.

Effective date: _____ Contract number: _____ Group number:
_____

Full name of subscriber: _____ Relationship: _____ Subscriber's DOB:_____

Subscriber's place of employment:
_____

What are your current concerns for this child: _____

_____

_____

How long has he/she been having these problems? _____

Why do you think the child is having these problems? _____

Tell us what goals you/your child have for his/her treatment:
_____

_____

_____

Please check the word that describes the severity of the child's problem:

☐ Mild ☐ Moderate ☐ Severe ☐ Extremely Severe ☐ Totally Incapacitating

Are there any situations at home that might have an effect on the child's behavior? _____

_____

Has the child threatened or attempted to harm themselves or others? _____ Yes _____ No

If yes, please explain: _____

_____

What was done as the result of this occurring? _____

_____

Whose idea was it to have the child brought to this clinic for help? _____

What would you/child like to do differently in your/their life? _____

_____

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Family Information:

Mother's name: _____ Age: _____ Maiden name: _____

Address: _____

Home Phone: _____ Work: _____Work Schedule: _____

Check one:___ Biological Mother ___ Foster Mother ____ Adoptive Mother ____ Legal Guardian

Marital status: ____Married to child's father ____ Separated ____Divorced ____ Remarried ____ Single

____Widowed ____ Living together

Employed? ____ Yes ____ No If yes, place of employment and job title: _____

_____

Father's name: _____ Age: _____

Address: _____

Home Phone: _____ Work: _____Work Schedule: _____

Check one: ___Biological Father ___ Foster Father ____ Adoptive Father ____ Legal Guardian

Marital status: ____Married to child's mother ____ Separated ____Divorced ____ Remarried ____ Single

____Widowed ____ Living together

Employed? ____ Yes ____ No If yes, place of employment and job title: _____

Name of Step-Parent(s) if applicable: _____

Is child adopted? ____ Yes ____ N

If yes, age of child when she/he was adopted: _____ Does child know of the adoption? No Yes

Who does the child live with? Please provide the following information with respect to all household members:

Name	Age	Sex	Relationship to child
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Please list any brothers or sisters who do not live with the child:

Name	Age	Sex	Relationship to child
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How would you describe the quality of your child's family relationships?

_____

_____

_____

Other than parents, describe significant caretakers:_____

_____

Medical History:

Child's primary care physician: _____ Phone #: _____

Address: _____

Date child last saw physician: _____ Reason: _____

If there is no regular physician, what do you do if the child needs to see a doctor? _____

_____

Immunizations up to date? _____ Yes _____ No If no, please explain: _____

_____

Child's height: _____ Weight: _____ Appetite: _____

Please check: _____ Recent weight gain? _____ Loss? _____ Does child over-eat _____ Binge? _____ Purge?

Does your child have any disabilities, disorders, or medical concerns that will affect his/her treatment at Wentworth & Associates? If yes, please explain: _____

_____

_____

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Please provide information with regard to the most recent following exams:

Exam	**Age**	**Result**
Last Vision Exam		
Last Hearing Exam		
Last Dental Exam		
Last TB Skin Test		
Other		

Has child/adolescent ever had trauma to the head or a closed head injury? Yes No If yes, please explain: ____

_____

Has child ever experienced loss of consciousness? Yes No If yes, please explain: _____

_____

Please provide information on any surgical procedures and/or hospitalizations experience by the child. Include dates and results if known: _____

_____

Is your child currently taking any prescribed medications? _____

If so what medications are you on and what are the dosages?

Medication	Dosage	Length of time on medication	What symptom is this medication targeting	Who prescribed this medication? (Psychiatrist, OB Gyn, PCP)	Is the medication helping? If so what percent?	If you starting this medication recently are you feeling significantly worse?	Are you having any side effects?

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Does the client consume caffeinated beverages? If so, how many per day? _____

Does the client consume any nicotine? If so, please estimate the amount. _____

Substance abuse? _____ Yes _____ No _____ Suspected If yes, or suspected, describe: _____

_____

History of substance/alcohol abuse: _____

Are there heavy drinkers in your family of origin? _____ Yes _____ No Whom? _____

Has anyone expressed concern over child/adolescent's drinking or use of drugs? _____ Yes _____ No

Please explain: _____

Has child had treatment for alcohol or other chemical dependencies? If so, when and where? _____

_____

Please check any of the following recreational chemicals that child/adolescent has used.
(Rarely = 1 x per month Often = 1x to 2x per week Very Often = Daily/most days per week)

	Past					**Current**				
	Never	Tried	Rarely	Often	Very often	Never	Tried	Rarely	Often	Very often
Alcohol										
Marijuana										
Cocaine										
Crack										
Sedatives										
Tranquilizers										
Painkillers										
Barbiturates										
Heroin										
Hallucinogens										
Crystal Meth										
Ecstasy										

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How many times per week do you drink or use chemicals? _____

How many drinks or how much substance do you use per occasion? _____

Current and/or past conditions (please check all that apply)

- ☐ ABDOMINAL PAIN
- ☐ ABNORMAL BALANCE
- ☐ ABNORMAL SENSE OF SMELL
- ☐ ALLERGIES
- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ASTHMA/WHEEZING
- ☐ BLADDER TROUBLE
- ☐ BLEEDING/BRUISING
- ☐ BLOOD IN URINE
- ☐ BLURRED/DOUBLE VISION
- ☐ BONE FRACTURES
- ☐ BOWEL DISTURBANCES
- ☐ BREATHING PROBLEMS
- ☐ CANCER/TUMOR
- ☐ FAINTING SPELLS
- ☐ FAST HEARTBEAT
- ☐ FEEL SHAKY OR TREMBLING
- ☐ FREQUENT EAR INFECTIONS
- ☐ FREQUENT INFECTIONS
- ☐ FREQUENT SORE THROAT
- ☐ FREQUENT URINATION
- ☐ GLAUCOMA
- ☐ GOUT
- ☐ GYNECOLOGICAL PROBLEMS
- ☐ HEARING PROBLEMS
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEPATITIS A, B, OR C
- ☐ HERPES
- ☐ NOSEBLEEDS
- ☐ NUMBNESS/TINGLING
- ☐ PALPITATIONS
- ☐ PNEUMONIA
- ☐ PREGNANCY
- ☐ RECTAL DISCHARGE
- ☐ RASHES/HIVES
- ☐ RECTAL BLEEDING
- ☐ RHEUMATIC FEVER
- ☐ SCARLET FEVER
- ☐ SHORTNESS OF BREATH
- ☐ SICKLE CELL DISEASE
- ☐ SINUS PROBLEMS
- ☐ SKIN RASHES
- ☐ SORE THROAT/MOUTH/TONGUE

- ☐ CHANGE IN APPETITE
- ☐ CHEST PAIN
- ☐ CHRONIC COUGH
- ☐ CHRONIC FATIGUE
- ☐ CONSTIPATION
- ☐ CONVULSIONS
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV/AIDS
- ☐ IRREGULAR HEARTBEAT
- ☐ JAUNDICE
- ☐ JOINT PAIN
- ☐ KIDNEY DISEASE
- ☐ SEXUAL PROBLEMS
- ☐ STROKE
- ☐ SWEATUNG
- ☐ SWOLLEN FEET OR ANKLES
- ☐ THYROID DISEASE
- ☐ TICS/TWITCHING

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☐	COUGHING UP BLOOD	☐	LIVER DISEASE	☐	TREMOR
☐	DENTAL PROBLEMS	☐	LOSS OF CONCIOUSNESS	☐	ULCERS
☐	DIABETES	☐	LOW BLOOD SUGAR	☐	URINARY INFECTIONS
☐	DIARRHEA	☐	MANY CHEST COLDS	☐	VENEREAL DISEASE
☐	DIFFICULTY WITH SPEECH	☐	MEASLES/RUBELLA	☐	VISION CHANGE
☐	DIFFICULTY STARTING URINATION	☐	MENSTRUAL PAIN	☐	VOMITING BLOOD
☐	DIZZINESS	☐	MUSCLE PAIN	☐	WEIGHT CHANGE
☐	EMPHYSEMA	☐	MUSCLE SPASMS	☐	WHEEZING, GASPING
☐	ENCEPHALITIS	☐	NAUSEA/VOMITING	☐	WORSENING EYESIGHT
☐	EPILEPSY	☐	NIGHT SWEATS	☐	OTHER

Developmental history:

Pregnancy/Labor/Delivery: _____ Term? _____ Preterm Delivery? _____ Birth weight?

Pregnancy complications: _____ Yes _____ No

Prenatal exposure to drugs and/or alcohol? _____ Yes _____ No If yes, please explain: _____

_____

Complications at birth? _____ Yes _____ No

Maternal postpartum depression: _____ Yes _____ No

Infancy (0-18 mos.): Please check all that apply:

☐ Medical problems ☐ Feeding problems ☐ Sleep problems ☐ Unusual fears

☐ Abnormal response to others ☐ Parental illness ☐ Prolonged Separations

☐ Separation problems ☐ Head banging or self injury

Motor Milestones: Crawled: _____ Sat unassisted: _____ Stood Unassisted: _____ Walked: _____

Toddlerhood (18-36 mos.): Please check all that apply:

☐ Aggression ☐ Tantrums ☐ Self-Injury ☐ Control Battles ☐ Unusual or Intense Fears

☐ Sleep problems ☐ Night Terrors ☐ Parental Illness ☐ Prolonged Separations

☐ Separation problems ☐ Sleep in Parental Bed

Toilet Trained: _____ Weaned: _____ Fed Self: _____ Dressed Self: _____ Spoke: _____

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Preschool (3-5 yrs.): Please check all that apply:

☐ Aggression ☐ Tantrums ☐ Self-Injury ☐ Frequent Injuries ☐ Unusual Fears

☐ Toilet Difficulties ☐ Sleep Problems ☐ Oppositionality ☐ Separation problems

☐ Prolonged Separations ☐ Parental Illness ☐ Fire Setting

☐ Bedwetting ☐ Soiling of underwear ☐ Tied Shoes ☐ Help with household tasks

Childhood (6-12 yrs):

☐ Medical problems ☐ Aggression ☐ Self-Injury ☐ School Changes ☐ Family Moves

☐ Suspensions/Expulsions ☐ Divorce or Parental Illness/Death ☐ Fire Setting ☐ Animal Cruelty

☐ Sleep problems ☐ School Absences ☐ Wetting/Soiling self ☐ Weight Issues

☐ Police/Legal problems ☐ School Refusal ☐ School failure ☐ Sexual Behavior ☐ Defiance

☐ Learning Problems ☐ Running Away ☐ Friendship Problems ☐ Trauma

☐ Exposure to violence or trauma ☐ Unusual or Excessive Rituals ☐ Premature puberty ☐ Family Discord

Language and Reading skills: _____ As expected _____ Having problems

Coordination: Can: _____ Ride a bike _____ Catch a ball _____ Write in cursive

Special Education Services? _____ Yes _____ No

Repeated or accelerated a grade? _____ Yes _____ No

Girls: First menstrual period: Not yet _____ Yes, Age: _____

Boys: Voice changes: Not yet _____ Yes, Age: _____

Adolescence (13-17 yrs):

☐ Medical problems ☐ Aggression ☐ Self-Injury ☐ School Changes ☐ Family Moves

☐ Suspensions/Expulsions ☐ Financial Strain ☐ Fire Setting ☐ Animal Cruelty ☐ Animal Cruelty

☐ Gender Identity Issue ☐ Anger/Hold Grudges ☐ School Absences ☐ Sleep problems ☐ Sexual Activity

☐ Police/Legal problems ☐ School Refusal ☐ School failure ☐ Bizarre Behavior ☐ Pregnancy

☐ Learning Problems ☐ Running Away ☐ Self Mutilation ☐ Family Discord ☐ Defiance

☐ Exposure to violence or trauma ☐ Unusual/Excessive Rituals ☐ Friendship problems ☐ Sexual Identity/ Preference Issue ☐Divorce/Parental illness/death or

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Plays sports: _____

Has hobbies: _____

Milestones met: Driver's license, age: _____ Dating, age: _____ First job, age: _____

Has child ever been involved with police or juvenile court? _____ Yes _____ No If yes, explain: _____

_____

Has child ever been physically abused? _____ Yes _____ No

Has child ever been sexually abused? _____ Yes _____ No

Has there ever been a Protective Service case opened related to this child or family? _____ Yes _____ No

Sexual/Gender Issues (describe any sexual activity or gender concerns you have about this child): _____

_____

_____

Mental Health History

Has child had previous counseling, therapy, or psychiatric treatment? _____ Yes _____ No

If yes, please specify where, when: _____

Results of treatment: _____
_____

Has anyone been admitted to a state or local psychiatric facility? _____ Yes _____ No

If yes, please specify where and date of admission: _____

_____

☐ Residential ☐ Partial Hospital Program ☐ Outpatient ☐ Case Management ☐ Crisis Stabilization

☐ A.C.T. (Assertive Community Treatment) ☐ S.E.P. (Support Employment Program)

☐ Family Support Services ☐ Prevention

Indicate whether the child is involved with any other Human Service Agency, as applicable:

☐ Dept. of Social Services ☐ Dept. of Public Health ☐ Substance Abuse Agency ☐ Prison ☐ Jail

☐ Community Corrections ☐ Parole ☐ Aging Services ☐ Courts ☐ School

Is child presently receiving wrap-around services? _____ Yes _____ No

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Education

Grade child is in: _____ Name of School: _____ Phone #: _____

Teacher: _____ Counselor: _____

Social Worker: _____

Does child receive tutoring outside of school? _____ Yes _____ No

Has child been tested by the school for learning problems? _____ Yes _____ No

Describe the child's school attendance: _____

Has child had previous psychological testing? _____ Yes _____ No

Describe child's attitude toward school: _____

Describe child's past/current behavioral adjustment in school:_____

_____

Describe any problems (social or academic) that you think your child may have at school: _____

_____

When/why did school behavior or academic performance change? _____

_____

Does child work? _____ How many hours a week? _____

Interests/Activities

(Please check all that apply to this child)

☐ WATCH TV	☐ SCHOOL	☐ BABYSIT
☐ TALK ON PHONE	☐ BE WITH FRIENDS	☐ VIDEO GAMES
☐ RIDE BIKE	☐ PLAY SPORTS	☐ DOLLS
☐ PAINT	☐ ROLLER BLADE	☐ COLLECT THINGS
☐ WRITE	☐ DRAW	☐ READ
☐ SEW/KNIT/CROCHET	☐ CRAFTS	☐ IMAGINARY PLAY
☐ SKATE	☐ LISTEN TO MUSIC	☐ BUILD THINGS

OTHER: _____

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Please circle any of the following words that you might use to describe your child/adolescent:

Intelligent	Confident	Worthwhile	Ambitious	Sensitive	Loyal	Trustworthy	Full of regrets
Useless	A nobody	Evil	Crazy	Considerate	Deviant	Unattractive	
Confused	Ugly	Stupid	Naïve	Incompetent	Horrible Thoughts		Honest
Hardworking	Can't make	Suicidal ideas	Persevering	Good sense of humor	Unattractive		Unlovable
Attractive	Worthless	Morally Degenerate	Conflicted	Other: _____			

Strengths & Abilities:

What do you think are your child's strengths and abilities?

_____

_____

Describe your family strengths and abilities:

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____

Child/Adolescent Signature: _____ Date: _____

Clinician Signature, Credentials: _____ Date: _____

Clinician Name (print): _____

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Wentworth & Associates, PC
11111 Hall Road, Suite 303
Utica, MI 48317
586-997-3153

Youth Outcome Questionnaire (YOQ30)

Name: _____ Therapist: _____ Date: _____

Instructions: You may discover that some of the items do not apply to your current situation. If so, please do not leave these items blank, but check the "never/almost never" category. When you begin to complete the YOQ30 you will see that you can easily make yourself as health or unhealthy as you wish. Please do not do that. If you are as accurate as possible, it is more likely you will be able to receive the help that you are seeking.

Read each statement carefully. Check the number that best describes how true the statement has been during the past 7 days. Check only one answer for each statement.

Directions for parents/guardians completing the questionnaire for children under 12: Respond to the statements as if each began with "My child…" or "My child's…" rather than "My" or "I" It is important that you answer as accurately as possible based on your own observations and knowledge.

Person Completing the form: Please circle one

Adolescent Parent/Guardian Other

1. **I have headaches or feel dizzy.**
   O 0 Never/ Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
2. **I don't participate in activities that used to be fun.**
   O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
3. **I argue or speak rudely to others .**
   O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
4. **I have a hard time finishing my assignments or do them carelessly.**
   O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
5. **My emotions are strong and change quickly .**
   O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
6. **I have physical fights(hitting, biting, or scratching) with family or others my age.**
   O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
7. **I worry and can't get thoughts out of my mind.**
   O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
8. **I steal or lie.**
   O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
9. **I have a hard time sitting still(or I have too much energy).**
   O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
10. **I use drugs or alcohol.**
    O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
11. **I am tense and easily startled(jumpy).**
    O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
12. **I am sad or unhappy.**
    O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
13. **I have a hard time trusting family members or other adults.**
    O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always
14. **I think others are trying to hurt me even though they are not.**
    O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

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15 I have threatened to run away from home or have run away from home.
O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

16 I physically fight with adults.
O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

17 My stomach hurts or I feel sick more than others my age.
O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

18 I don't have friends or I don't keep friends very long.
O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

19 I think about suicide or feel I would be better off dead.
O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

20 I have nightmares, trouble getting to sleep, oversleeping, or waking too early.
O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

21 I complain about or question rules, expectations or responsibilities.
O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

22 I break rules, laws, or don't meet others' expectations on purpose.
O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

23 I feel irritated.
O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

24 I get angry enough to threaten others.
O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

25 I get in trouble when I am bored.
O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

26 I destroy property on purpose.
O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

27 I have a hard time concentrating, thinking clearly, or staying on task.
O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

28 I withdraw from my family and friends.
O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

29 I act without thinking and don't worry about what will happen.
O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

30 I feel that I don't have any friends or that no one likes me.
O 0 Never/Almost Never O 1 Rarely O 2 Sometimes O 3 Frequently O 4 Almost always

Wentworth and Associates Issue Specific Questions

1. Please list the issue that prompted you to seek treatment: _____

2. Regarding this issue, how much distress is it causing you at this time? Please circle the number that corresponds to your level of distress:

No distress 0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10 A lot of distress

3. Please rate your level of satisfaction with the treatment you have received at Wentworth and Associates thus far.

No treatment 0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10 Very Satisfied

Staff Use:
Check One

___ Intake Assessment
___ Quarterly Assessment
___ Discharge Assessment

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Wentworth & Associates, P.C.
COORDINATION OF CARE CONSENT FORM

Patient's name:

_____

DOB _____/_____/_____

SSN# - -

I,_____hereby ____authorize

___ do not authorize Wentworth & Associates, P.C. to release and/or obtain confidential information ____my child's/ward's patient records to and from the following physician(s): (Info Primary Care Physician, check here___ and sign below.)

My Primary Care Physician_____

Physician's Name

Address or Fax Number _____

Information to be disclosed:

___ Diagnoses_____

___Medical Information_____

___Assessments/Testing Information_____

___Other_____

Instructions/Requests:

_____

_____

Purpose of such disclosure:

___ Coordination of Care_____

___Other_____

Client Signature_____ Date_____

Parent/Guardian Signature_____ Date_____

Witness Signature_____Date_____

The use of this consent by Wentworth & Associates, P.C. is effective for one year from the date of signature, and may be revoked by myself, in writing at any time. This consent is being signed voluntarily and under no circumstances is a precondition of treatment.

Date Condition or Event for Revocation of this form_____

Please send requested information to:

_____

Requesting Clinician's name

Wentworth and Associates, P.C. or FAX 586-997-4956

11111 Hall Rd Suite 303

Utica, MI 48317

This form was __ Mailed ___ Faxed ____ other (Specify) to the PCP above

Original: Clinical record Copy: Primary Care Physician Rev 02/09/2016

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Note: For your child's protection, children under the age of 12, MUST be accompanied by an adult in our waiting rooms

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