Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

3240 Burnt Mill Drive ▪ Suite 1 ▪ Wilmington, NC 28403 ▪ Tel: 910-790-9500 ▪ Fax: 910-796-8111

RIGHTS & CONSENT TO TREATMENT

- ❑ You have the right to be respected as an individual, regardless of your gender, race, religion, sexual orientation, or disability status.
- ❑ You have the right to be treated in accordance with professional and ethical standards of conduct.
- ❑ You have the right to confidentiality. We will not disclose any information outside of the Chrysalis Center without your written consent. Clinical records will be maintained in a secure, locked environment. Please be advised that state law requires that confidentiality be broken in certain emergency situations, such as to protect you or someone else from imminent danger, to report child or elder abuse, or if mandated by a court order. We will not sell your information to anyone for any reason.
- ❑ I understand that if Chrysalis shares any information, we will adhere to the "minimum necessary" rule to protect your confidentiality and we will not share Psychotherapy Notes with any third parties.
- ❑ You have the right to discontinue therapy at any time. However, it is expected that you will confer with your therapist rather than end treatment abruptly. If you decide to discontinue treatment, you have the right to request a treatment summary and referrals to other professionals.
- ❑ I understand that sessions run for 45-50 minutes and will not be extended to accommodate tardy clients. In addition, if your session runs beyond the allotted time (such as in an emergency situation), your fee will be adjusted accordingly.
- ❑ I consent to take part in treatment with this clinician. I understand that it is in my best interest to actively participate in treatment and follow treatment recommendations.
- ❑ I understand that there is no guarantee that any particular outcome will result from treatment.
- ❑ I understand and give my consent for the Chrysalis Center clinical staff to consult with each other as needed in order to provide me with the most effective, ethical treatment possible. The clinicians and nutritionists actively collaborate and consult about mutual cases, as well as share clinical notes.
- ❑ I understand that my therapist may consult and share clinical information with her supervisor and/or clinical board and/or university in order to provide legal and ethical treatment. She may also do so to meet the requirements set forth for licensure or certification. If I am being seen by an intern, I understand that they are not yet licensed and are practicing under the auspices of their graduate program, not Chrysalis Center.
- ❑ I understand that all communications with Chrysalis staff, including digital interactions, will be part of my clinical record. Any digital communication will be limited to that which does not compromise the clinical relationship or professional and ethical standards. I will discuss appropriate ways to use digital technology with my clinician. I understand that any communication via social media is prohibited. If I choose to communicate via digital media (cell phones, text, email, etc.), I understand that the confidentiality of these interactions cannot be guaranteed, although any Chrysalis-based digital communications will utilize appropriate security measures.

I have read and understood this document and will address any concerns or questions with my therapist and/or the office manager. Chrysalis Center reserves the right to change this agreement as necessary and in accordance with all applicable laws. Current copies of this agreement can be requested anytime and are available on our website.

Client/Representative Signature _____ **Date** _____

I have addressed the client's/parent's/guardian's concerns and/or questions. The client appears fully competent to give informed consent.

Clinician Signature _____ **Date** _____

Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

3240 Burnt Mill Drive ▪ Suite 1 ▪ Wilmington, NC 28403 ▪ Tel: 910-790-9500 ▪ Fax: 910-796-8111

ACKNOWLEDGEMENT OF RECEIPT - NOTICE OF PRIVACY PRACTICES & CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____, and Chrysalis Center. When we use the word "you" below, it can mean you, your child, a relative or other person if you have written his or her name(s) here _____.

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information to decide what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you, with others who need it to arrange payment for your treatment, or with others for other business or government functions. By signing this form you are agreeing to let us use your information and send it to others under the circumstances described in our Notice of Privacy Practices. Please read this Notice before you sign this form; it explains in more detail your rights and how we can use and share your information.

In the future we may change how we use and share your information; therefore our Notice of Privacy Practices may change. If this occurs, you can get an updated copy from our website, www.chrysaliscenter-nc.com, or by calling us at 910-790-9500. If you have any questions regarding the Notice or your privacy rights, you can also contact Kendra Wilson, LCSW, Privacy Officer, at kendra@chrysaliscenter-nc.com or at the address listed below.

Please note that it is your right to protect your information. If you have concerns about the use or share of your information for treatment, payment, or administrative purposes, please submit a written request to our Privacy Officer at Chrysalis Center about these concerns. (Although we will try to respect your wishes, we are not required to agree to these limitations.) Furthermore, you have a right to revoke this consent after you have signed it (by submitting a letter to the Privacy Officer). Any information used or shared prior to annulment of this consent cannot be changed.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to detail what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations; more information about these limitations is detailed in the Notice of Privacy Practices. If you object to any of these practices, you may discuss them with our staff and/or provide written documentation of your concerns. After you have signed this consent, you have the right to revoke it (by writing a letter to our Privacy Officer telling us you no longer consent) and we will comply with your wishes as thoroughly as we are able to do so under the law.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Chrysalis Center's Notice of Privacy Practices. My signature indicates that I have reviewed this notice, understand its content, and agree to its stipulations.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

Relationship to Client (if guardian or representative):_____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (relationship to the client, power of attorney, healthcare surrogate, etc.).

☐ I would like to opt out of receiving any fundraising, business or marketing communications from Chrysalis.

☐ I would like to opt out of any research conducted at Chrysalis using outcomes data.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

☐ ***Client Refuses to Acknowledge Receipt:***

Signature of authorized representative of this office or practice: _____

Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

3240 Burnt Mill Drive ▪ Suite 1 ▪ Wilmington, NC 28403 ▪ Tel: 910-790-9500 ▪ Fax: 910-796-8111

INFORMED CONSENT FOR PARENTS/GUARDIANS OF MINOR CHILDREN

Divorce, Custody or Legal Issues

As a mental health treatment facility our primary focus, responsibility and goal is the treatment and well being of our identified clients. In the case of a child as the primary client it is essential that parents and legal guardians are not in conflict and are in fact in agreement as to decision to treat, the treatment goals, appointment times and the need to maintain client confidentiality. The therapeutic process is a team approach, especially in the case of a minor child. The following informed consent states that each parent, and/or any legal guardian with authority over the health care decisions of the child, will agree to these terms and communicate effectively with each other as well as with the provider to create a supportive environment for treatment and to assist our clinicians toward attempting to achieve the most positive outcome possible.

Although our responsibility to your child may require our involvement in conflicts between parents and guardians, we need your agreement that our involvement will be strictly limited to that which will benefit your child. This means, that you each agree as a condition of us treating your child that (please check to indicate you understanding):

- ☐ You shall treat anything that is said in any individual or group therapy session as strictly confidential;
- ☐ Our role is limited to providing treatment and you shall not attempt to gain advantage in any legal proceeding relating to the care and custody of your child from our treatment of your child;
- ☐ You shall not request or require us, through subpoena, summons or other means (except as otherwise ordered by a court of competent jurisdiction), to provide testimony in favor of one parent or guardian against the another in any legal proceeding relating to the care and custody of your child; and
- ☐ If multiple parents or guardians desire to obtain treatment information and/or testimony from any one of our clinicians relating to your child in any legal proceeding you shall each consent to the disclosure by executing one or more authorization forms we send to you and you will each share in the cost of producing such records and/or written or live testimony at our established copying charges and/or hourly rates for our clinician's time.

If there is a court appointed evaluator, and if appropriate authorization forms are signed, or a court order authorizing disclosure of treatment records is sent to us, we will disclose the requested treatment and general information about the minor but we will not make any recommendations concerning the child's custody or custody arrangements, unless otherwise ordered by a court.

Scheduling & Payment

I give my permission to the following people to make decisions regarding therapeutic interventions, scheduling appointments and cancelling appointments, if I am not physically present during any appointments:

Name	Relationship to Client	Contact Information (phone and/or email)

- ☐ I accept the responsibility of communicating with appropriate parties after every appointment to be updated regarding any change in the treatment plan related to the minor child's therapy.
- ☐ I understand that as the custodial parent of the minor child, I am responsible for **any and all** payments due. Any payment received from the minor child's other parent, guardian, or family member will be deducted and applied appropriately to the child's account. If the account is in default or a payment has not been made, Chrysalis Center will look to me as the sole party responsible for the financial obligations of the account.
- ☐ I understand that if my child is over the age of 16, they may make and cancel their own appointments. I will be required to put a credit card on file and complete a Third-Party Payer Agreement that will be used to pay for your child's treatment.
- ☐ I understand that If my child has their 18th birthday during the course of treatment, they may be required to fill out new paperwork to give their consent to treatment, payment responsibility, and/or if you will still be permitted to speak with the treatment team without your child present. Your child may need to complete a Release of Information to allow you to speak with **any** administrative or clinical staff about their care or appointments.

I have read and understood this document and will address any concerns or questions with the practice manager.

I have read the above consent over carefully and understand its content and hereby agree to the terms and conditions and consent to the treatment of my child under these terms and conditions set forth above by signing below.

Chrysalis Center reserves the right to change this agreement as necessary and in accordance with all applicable laws. Current copies of this agreement can be requested anytime and are available on our website. This informed consent is signed in addition to the forms regarding Client Rights and Consent to Treatment, HIPAA/Confidentiality, Financial Agreement, and any Release of Information on file.

Minor Child Name **(please print)**:_____

Parent/Guardian **Name (please print):** _____

Parent/Guardian **Signature:** _____ **Date** _____

I have addressed the client's/parent's/guardian's concerns and/or questions, if any. The parent/guardian appears fully competent to give informed consent.

Staff Signature _____ **Date** _____

Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

3240 Burnt Mill Drive ▪ Suite 1 ▪ Wilmington, NC 28403 ▪ Tel: 910-790-9500 ▪ Fax: 910-796-8111

THIRD PARTY PAYER AGREEMENT

I accept full financial responsibility for the treatment of _____ (client name) and agree to the provisions of the Office Procedures & Financial Agreement.

Please indicate preferred method	Payment Options
	Credit card payment: You may provide the client with a credit card to present at the time of service or we can manually enter your credit card information (VISA/MC only) Card Number: _____ Exp Date: _____CVC Code: _____ Zip code: _____
	Payment at the time of service: You may provide the client with cash or check to remit when he/she comes in for an appointment. If, for whatever reason, the client runs a balance, you will need to provide a credit card number we can maintain on file.

You may elect to have a statement sent to you at the beginning of each month. The statement will reflect all payments you made for the previous month. If you would like a statement sent to you, please indicate your preferred method and include necessary information:

_____ _____
Email Fax Number

_____

_____

Mailing Address

_____ _____
Signature of Third-Party Payer Date

_____ _____
Print Name of Third-Party Payer Contact Phone Number

Below to be filled out by client (if over 18)

I, _____ (client name) authorize the above to accept full financial responsibility for any services rendered at Chrysalis. I understand that by authorizing a Third-Party Payer, that individual may obtain financial or billing information about my services at Chrysalis such as date of service, type of service, fee for service, and service provider. No clinical information will be given without a separate Release of Information.

_____ _____ _____
Signature of Client Date Date of Birth

Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

3240 Burnt Mill Drive ▪ Suite 1 ▪ Wilmington, NC 28403 ▪ Tel: 910-790-9500 ▪ Fax: 910-796-8111

OFFICE PROCEDURES AND FINANCIAL AGREEMENT

Please read, initial, complete, and sign below. You may request a copy for your records.

Chrysalis is a business office where a number of mental health professionals, registered dietitians, and a psychiatric provider practice. Your contract for services is with our office and applies to any and all providers you may see here.

APPOINTMENTS:
All office visits are by appointment and scheduled through our administrative staff. Please arrive on time, as you cut down on your appointment time when you arrive late. Appointment lengths vary depending on the type of provider seen. If you arrive more than 15 minutes late, you will be asked to reschedule your appointment, which will result in a *late cancellation* charge.

PAYMENT:
Payment is required at the time services are rendered, whether you are a self-pay client or have insurance coverage. Acceptable methods of payment include cash, check, VISA or Master Card. *The fee for returned checks is $35. If a check is returned, you will be asked to arrange another method of payment.*

All clients are required to place a credit card on file in order to facilitate collection of payment. If estimated payment (copay, deductible, coinsurance, cash rates) is not received by the end of the date of service, the card on file will be charged. In the case that insurance reimburses different amounts than the estimated payment taken, credits and debits will be applied to the card immediately. If the card declines, you will have until one business day prior to your next appointment to provide current and valid card information or your scheduled session will be canceled and payment in full will be required before you can reschedule. A patient portal via our electronic medical records system will be provided to view and track payments.

Name (as it appears on the card): _____

Card Number: _____

Phone number of credit card holder: _____ Billing Zip code: _____

Expiration Date: _____ CVV/CVC: _____

Signature of Cardholder: _____

Late cancellations/No shows: For a missed or late cancelled appointment, you will be charged up to $60 for the appointment. Please note: both clinical and nutritional appointments must be cancelled no less than one business day before the scheduled appointment. Please be advised that reminder calls are a courtesy, and you will be billed for late cancellations and no-shows regardless of whether or not you received the reminder message. Repeated late cancellations and/or no-shows may result in dismissal from treatment, at our discretion.

INSURANCE:
As a courtesy to you, we will bill rendered services to your insurance carrier. We do not accept Medicaid. Insurance co-payments, coinsurances, and deductible payments are due at the time of service. However, verification of eligibility and/or benefit information is not a guarantee of payment by your insurer. Your benefits will be determined once a claim is processed by your insurer, which will be based upon your eligibility and the terms of your certificate of coverage applicable on the date services were rendered. In the event of non-payment from your carrier, you are responsible for payment to Chrysalis for services rendered and you will be responsible for handling any disputes with your insurance carrier. *It is your responsibility to be aware of your insurance benefits and needs for pre-authorization. Any services not covered by your insurance are your responsibility.*

Unless otherwise notified, the insurance policy holder will be financially responsible for any balance on the client's account. Please make one of our administrative staff aware if the billing address is different than the home address on file. Please note: treatment information including diagnosis, type of treatment, costs of service, dates of service, and providers may be shared with your insurance carrier for reimbursement purposes. Please be aware that any information communicated to your carrier may affect your benefits. If you decide to file through insurance, we reserve the right to share this information with your carrier upon their request.

OUTSTANDING BALANCE: You are responsible for paying any outstanding balances due on your account. Once we receive an Explanation of Benefits from your insurance carrier, your balance may be adjusted based on your carrier's allowed amount. If an account accrues two or more unpaid sessions, ongoing services may be immediately postponed until full remittance is received. Please be advised that if Chrysalis does not receive payment in full for services rendered, your treatment may be discontinued.

If you are unable to pay your balance in full, a signed *payment plan agreement* will be implemented immediately. Failure to adhere to your payment plan is grounds for discontinuation of services. If you previously discontinued your care or were discharged from treatment and you desire to resume receiving services at Chrysalis, you will be expected to remit any unpaid balance prior to being seen. Payment plans may be arranged with our administrative staff. Any balance not paid in 90 days will be subject to collections.

Late Fees: A late fee of $25 will be charged to delinquent accounts that are not paid within 90 days of the issue date of the first bill and may also be referred to a third-party collection agency. You will continue to be responsible for all associated collections and fees.

ADDITIONAL SERVICES: In some circumstances, depending on the time involved and nature of task, you may be charged for additional services, such as extended sessions, scoring psychological testing, preparing a psychological report, writing letters of advocacy or documentation on your behalf, extensive clinical coordination, and extended consultations with other providers regarding your treatment. Phone calls that are extended and/or that constitute therapy may require an additional fee. These additional services will be charged up to $100/hour.

Testing Fees: Charges for psychological testing apply to all tests taken and scored. Sometimes, insurance companies do not reimburse for testing. In this event, you will be responsible for uncovered testing costs at our self-pay rate.

Conjoint Sessions (with more than one therapist): Conjoint sessions will be billed according to your benefits, which may result in a self-pay rate.

Please note: No provider at Chrysalis will fill out any disability forms (FMLA, short or long term, etc.) for clients who are not already established at Chrysalis (5+ sessions with one provider), and at the clinician's discretion. We will send records as requested to other providers or agencies with a valid Release of Information on file. If records are sent, there may be a $25 administrative fee associated with sending the records or filling out any paperwork for a third party.

Changes to the Policy: Chrysalis Center reserves the right to change this agreement as necessary and in accordance with all applicable laws. Current copies of this agreement can be requested anytime and are available on our website.

Please initial at each line and sign below to indicate that you have read, understood, and agree to the above policies. For minors, parent/guardian must sign.

_____ I have read, understand, and agree to the above policies.

_____ I authorize Chrysalis to release any information acquired in the course of my therapy to my insurance company as needed.

_____ I understand my insurance coverage is a relationship between me and my insurance company and I agree to accept financial responsibility for payment of charges incurred.

_____ I have been offered a copy of these policies to take with me if I desire.

_____ I understand that the credit card on file will be charged for services rendered if I do not make alternative arrangements at time of service

_____ I have discussed these policies and addressed concerns and questions with the administrative staff if needed. Initial and date by administrative staff if questions were addressed: _____

_____ _____

Signature of Client Date

Please initial at each line and sign below to indicate that you have read, understood, and agree to the above policies. For minors, parent/guardian must sign.

_____ _____

Signature of parent or Legal Guardian Date

Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

3240 Burnt Mill Drive ▪ Suite 1 ▪ Wilmington, NC 28403 ▪ Tel: 910-790-9500 ▪ Fax: 910-796-8111

**Insurance is filed as a courtesy. All unpaid balances will be the responsibility of the client. It is the client's responsibility to notify Chrysalis of any information that has changed.*

** Please see reverse side for secondary insurance information and consenting signature.*

Please Note: Your insurance carrier requires us to gather this information in order to use your benefits, and the following information is not available on your insurance card. You must complete all fields on both pages of this form. If you do not provide us with accurate information, your claims may not be processed appropriately, and you will be charged the full rate for services already rendered.

_____ Please initial if you do not want to use your insurance benefits; you will be charged the self-pay rate for services.

INSURANCE INFORMATION

Client Information:

Full Name (Including Middle): _____

Address: _____

Telephone: _____

Birth Date: _____

Social Security Number: _____

Relationship to Policy Holder: _____

Primary Insurance Information (family member whose insurance you are covered by):

Policy Holder's Full Name (Including Middle): _____

Policy Holder's Address: _____

_____

Policy Holder's Telephone: _____

Policy Holder's Birth Date: _____

Policy Holder's Social Security Number: _____

Employer's Name: _____

Insurance Plan Name: _____

Subscriber Number or Member ID Number: _____

Group Number: _____

Secondary Insurance Information (If applicable):

Policy Holder's Full Name (Including Middle): _____

Policy Holder's Address: _____

_____

Policy Holder's Telephone: _____

Policy Holder's Birth Date: _____

Policy Holder's Social Security Number: _____

Employer's Name: _____

Insurance Plan Name: _____

Subscriber Number or Member ID Number: _____

Group Number: _____

I have read and completed the information above and verify that it is correct. I understand that it is my responsibility to update Chrysalis with any change in insurance information.

_____ _____

Name of Client (printed) Date

_____

Signature

Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

3240 Burnt Mill Drive ▪ Suite 1 ▪ Wilmington, NC 28403 ▪ Tel: 910-790-9500 ▪ Fax: 910-796-8111

CONFIDENTIAL CLIENT INFORMATION

TO BE COMPLETED BY PARENT/GUARDIAN FOR CHILDREN AGE 6-17:

Welcome to Chrysalis Center. Please complete the front and back of each page to help your clinician provide appropriate services. In accordance with our professional codes of ethics and state and federal laws, any information you provide is strictly confidential. ***These forms must be completed in their entirety prior to your first appointment, or you will not be able to see a provider at Chrysalis Center at that time.***

Demographic Information:

Child's Name: _____ Date: _____

Child's SSN: _____ Date of Birth: _____ Age: _____

Gender: _____ Ethnic Group: _____ Religious Preference: _____

Mailing Address: _____

_____

City: _____ **State:** _____ **Zip Code:** _____

Primary Parent/Guardian's Name: _____

Parent Email Address(es): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Which phone is the best way to contact you? _____ Is it okay to leave a message? Yes No

Relationship Status: _____Single _____Cohabitating _____Married
_____Separated _____Divorced _____ Widowed

If separated or divorced, what custody arrangements are in place? _____

_____

*Please also provide a copy of your custody agreement.

Other Emergency Contact: _____ Telephone: (_____) _____

Other Parent/Guardian Name (if relevant): _____

Email: _____ Telephone: (_____) _____

Address: _____

_____

Referral Information:

How did you find out about our services? _____

Clinical Information:

What type of services are you seeking/expecting for your child? (Please check all that apply to you)

_____Individual Counseling
_____ Group Counseling
_____ Family Counseling
_____ Nutritional Counseling
_____ Assessment

Mental Health History:

Have you or your child received counseling before? Yes No

If yes, when, where, and with whom? _____

_____

Family/Significant Others:

If anyone in your family has a history of the following, please check all that apply and specify on the chart above: Mental Illness _____ Substance Abuse _____ Eating Disorder _____ Obesity _____ Dieting _____

Please provide the following information about your family members (include everyone who lives in the child's household, i.e. parents, stepparents, all siblings, spouse/partner, children).

Name	Relationship to You	Age	Job/ Highest Education Completed	Where He/She Lives	Mental/Medical Conditions (mental illness, substance abuse, eating disorder, obesity, dieting)

Health Information:

Please list any chronic illnesses, injuries, physical conditions or disabilities: _____

_____

_____

Allergies/Adverse Reactions to Treatment: _____

_____

Primary Care Physician Name: _____

Date of Last Physical: _____ Telephone: (____) _____

Current Medications, Supplements, Vitamins	Daily Dose	Start Date	Name of Prescriber

In your own words, please identify the concern(s) that you want your child to address in counseling. Be as specific as you can. _____

_____

_____

Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

SYMPTOM CHECKLIST

Child's Name: _____ **Age:** _____ **Gender:** **Male** **Female** **Date:** _____

What is your relationship with the child receiving care? _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

During the past **TWO (2) WEEKS,** how much (or how often) has your child…			**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	

In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know	
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know	
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know	
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know	
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know	
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know	

Questions P1-P19 ask about the early development and early and current home experiences of your child. Some questions require that you think as far back as to the birth of your child. Your response to these questions will help your child's clinician better understand and care for your child. Answer each question to the best of your knowledge or memory.

Please choose one response (✓ or x) for each question.

Early Development		**No**	**Yes**	**Can't Remember**	**Don't Know**
P1.	Was he/she born before he/she was due (premature)?	☐	☐	☐	☐
P2.	Were the doctors worried about his/her medical condition immediately after he/she was born?	☐	☐	☐	☐
P3.	Did he/she have to spend any time in a neonatal intensive care unit (NICU)?	☐	☐	☐	☐
P4.	Could he/she walk on his/her own by the age of 18 months?	☐	☐	☐	☐
P5.	Has he/she ever had a seizure?	☐	☐	☐	☐
P6.	Did he/she ever lose consciousness for more than a few minutes after an accident?	☐	☐	☐	☐
Early Communication					
P7.	By the time he/she was age 2, could he/she put several words together when speaking?	☐	☐	☐	☐
P8.	Could people who didn't know him/her understand his/her speech by the time he/she reached age 4?	☐	☐	☐	☐
P9.	Have you ever been concerned about his/her hearing or eyesight?	☐	☐	☐	☐
P10.	By the time he/she was age 4, was he/she interested in playing with or being with other children?	☐	☐	☐	☐

Home Environment		No	Yes	Can't Remember	Don't Know
P12.	Has he/she ever been admitted to the hospital for a serious illness?	☐	☐	☐	☐
P11.	Was there ever a time when he/she could not live at home and someone else had to look after him/her?	☐	☐		☐
P13.	Does anyone at home suffer from a serious health problem?	☐	☐		☐
P14.	Does anyone at home have a problem with depression?	☐	☐		☐
P15.	Does anyone at home regularly see a counselor, therapist, or other mental health professional?	☐	☐		☐
P16.	Does anyone at home have a problem with alcohol, drugs, or other substances?	☐	☐		☐
P17.	Would you say that the atmosphere at home is usually pretty calm?	☐	☐		☐

		Less Than Once a Month	**Between Once a Week and Once a Month**	**More Than Once a Week**	**Most Days**
P18.	How often are there fights or arguments between people at home?	☐	☐	☐	☐
P19.	How often does your child get criticized to his/her face by other family members when he/she is at home?	☐	☐	☐	☐

If you would like to leave separate contact information than your parent/guardian, please complete the following:

Name: _____ Date: _____

Email Address(es): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Which phone is the best way to contact you? _____ Is it okay to leave a message? Yes No

Identified Ethnic Group: _____ Religious Preference: _____

Emergency Contact: _____ Telephone: (_____) _____

Employment Information:
Are you currently employed? Yes No
If yes, where are you employed? _____
What is your job title? _____

Education Information:
Are you currently a student? Yes No
If yes, where? _____ Year _____ Major _____

Family/Significant Others:
Please provide the following information about your family members (include parents, stepparents, all siblings, spouse/partner, children, etc.) and significant others.

Name	Relationship to You	Age	Where He/She Lives	Mental/Medical Conditions (mental illness, substance abuse, eating disorder, obesity, dieting)

If anyone in your family has a history of the following, please check all that apply and specify on the chart above: Mental Illness _____ Substance Abuse _____ Eating Disorder _____ Obesity _____ Dieting _____

Health Information:

Please list any chronic illnesses, injuries, physical conditions or disabilities: _____

_____

_____

Allergies/Adverse Reactions to Treatment: _____

_____

Current Medications, Supplements, Vitamins	Daily Dose	Start Date	Name of Prescriber

Clinical Information:

What type of services are you seeking/expecting? (Please check all that apply to you)

_____ Individual Counseling
_____ Group Counseling
_____ Couples/Family Counseling
_____ Nutritional Counseling
_____ Bariatric Evaluation
_____ Assessment

Mental Health History:

Have you received counseling before? Yes No

If yes, when, where, and with whom? _____

_____

Have you ever experienced any of the following?

_____ A recent and/or important loss (please specify)_____
_____ Physical Abuse
_____ Sexual Abuse/Molestation
_____ Sexual Assault
_____ Verbal/Emotional Abuse
_____ Suicidal Thoughts or Feelings
_____ Homicidal Thoughts or Feelings

Are you having current difficulties with any of the following?

_____ Self-Confidence/Self-Esteem
_____ Body Image
_____ Anger Management
_____ Peer Relationships
_____ Romantic Relationships
_____ Family Relationships
_____ Divorce/Separation
_____ Sexual Identity Issues
_____ Legal Problems
_____ Racial/Cultural Issues
_____ Other stress (please specify)_____
_____ Financial Problems
_____ Unemployment
_____ Learning Disabilities
_____ Loneliness/Social Isolation
_____ Career Planning
_____ Academic Performance
_____ Spirituality
_____ Decision Making
_____ Pregnancy (past, present)

How well are you getting along psychologically at this time?

_____ Very well, the way I want to.
_____ Quite well, no important complaints.
_____ Fairly well, but have ups and downs.
_____ So-so, can keep going with effort.
_____ Quite poorly, can barely manage.
_____ Very poorly, can't manage.

Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

During the past **TWO (2) WEEKS,** how much (or how often) have you…			**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
	In the past **TWO (2) WEEKS,** have you…							
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No				
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No				
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No				
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No				
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	☐ Yes	☐ No				
	25.	Have you EVER tried to kill yourself?	☐ Yes	☐ No				

Have any of these symptoms -- drinking, drug use, moods, anxiety, etc. – ever interfered with school, work, etc.? What concerns, if any, have family and friends expressed? Please explain. _____

Have any of these symptoms ever gotten you into trouble with the authorities and/or caused legal problems? If yes, please explain. _____

Has your health ever suffered as a result of any of these symptoms? If yes, please explain. _____

Have you ever received medication or treatment for any of these symptoms? If yes, please explain. _____

Were you ever hospitalized for any of these symptoms? If yes, please explain. Please list any hospitalizations for psychological, psychiatric, or chemical dependency treatment, including location and dates. _____

In your own words, please identify the concern(s) that you want to address in counseling. Be as specific as you can. _____

These forms must be completed in their entirety prior to your first appointment, or you will not be able to see a provider at Chrysalis Center at that time. *Portions of this form have been adapted from the American Psychological Association Diagnostic and Statistical Manuel 5's Cross Cutting Symptoms Measures for Adults and Adolescents.*