Client Information			
Youth Name:	DOB:	Today's Date:	
Address:	City:	State:	Zip:
SSN:	Phone:	Email:	
I Authorize SBHP to Leave Detailed Voice Messages at the Above Number: ☐ Yes ☐ No Text Reminders: ☐ Yes ☐ No			
Sex:	Gender:	Preferred Pronouns:	
Emergency Contact:	Relationship:	Phone:	
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic or Latino			
Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Native American ☐ Alaska Native ☐ Hawaiian/ Pacific Islander ☐ Other:			
Are you a Stillaguamish Tribal Member or Relative? ☐ Yes ☐ No	Other Tribal Affiliation:		
Youth Employer: ☐Full Time ☐Part Time			
Person Competing this Form:	Relationship:		
Primary Care Provider:	Location:		
Are you: ☐ Deaf/Heard of Hearing ☐ Blind/Vision Impaired	Interpreter Needed: ☐No ☐Yes: ☐ASL ☐Other:		
School Attending:	District:	Grade:	

Parent/Guardian Information		
Marital Status of Parents: ☐ Single ☐ Married ☐ Cohabiting ☐ Divorced ☐ Separated ☐ Widowed		
Mother's Name and age:		
Contact Phone Number(s): Home	Cell:	Work:
Father's Name and age:		
Contact Phone Number(s): Home	Cell:	Work:
If divorced, who has legal custody:		
Who has physical custody?		
Who has decision making authority regarding medical care?		

Current Problems
In your own words, describe the current problems that bring your youth mental health treatment:
How long has this been going on?
What are your goals for treatment?

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Household Information			
Name:	Age:	Gender:	Relationship to Youth:

Referral Information		
Is the youth court ordered to complete an assessment? (attach court order)	Yes	No
Is the youth/family involved with ICW, DCYF, Family Court or Open Guardianship Case?	Yes	No
Is the youth a Registered Sex Offender or Do You Have Any Pending Charges of This Nature?	Yes	No

Billing Information		
Primary Insurance	ID Number	Group Number
Subscriber Name		Subscriber DOB
Secondary Insurance	ID Number	Group Number
Subscriber Name		Subscriber DOB

Consent to Bill

I authorize SBHP to file a claim with my insurance carrier for services rendered. I understand that I am responsible for any part of the charges that are not covered/paid by my insurance and I will be billed directly for those services.

Privacy Statement

SBHP complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have received the SBHP Notice of Privacy Practices and Youth Rights.

Consent For Treatment

By signing this form, I consent to and authorize my provider(s) at SBHP to provide me treatment. I understand that I have the right to discuss all treatments with my provider(s) and I have the right to refuse treatment. All of my information is true and correct to the best of my knowledge.

My Signature Below Indicates That I Understand and Accept the Contents of this Form	
Youth Signature:	Date
(Youth must sign if age 13 or over)	
Parent/Guardian Signature:	Date
(Required if youth is age 12 or under)	

FRONT DESK STAFF USE	
Date received:	
CLINICAL STAFF USE	
Date staffed:	Clinician assigned:
Clinical notes:	

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Parent Questionnaire / Youth History

This questionnaire is to help us get to know the youth better in order to provide the best possible mental health services. Please answer the questions as honestly and completely as possible. Feel free to attach additional pages if necessary. All information you provide will be confidential as required by state and federal law.

Has the youth ever:

☐ Yes ☐ No Expressed thoughts of suicide?	☐ Yes ☐ No Harmed themselves intentionally?
☐ Yes ☐ No Attempted suicide?	☐ Yes ☐ No Been a victim of abuse or neglect?
☐ Yes ☐ No Experienced a significant loss?	☐ Yes ☐ No Been involved with Child Protective Services?
☐ Yes ☐ No Been involved with Probation/Court/Police?	

If you answered yes to any of these questions, please explain:

Pregnancy & Birth History

Were there any complications during pregnancy?

Were drugs or alcohol consumed during pregnancy? ☐ Yes ☐ No Youth's weight at birth:

Social & Emotional Development

Describe the youth's current social skills and peer relationships:

Does the youth have a history of being bullied/teased or has been aggressive in play with others ☐ Yes ☐ No

Please list the youth's favorite hobbies:

What are your youth's strengths?

Academic History

Has there been a change in the youth's performance at school?	☐ Yes ☐ No
Has the youth been suspended or expelled?	☐ Yes ☐ No
Has the youth participated in a 504 or IEP plan?	☐ Yes ☐ No
Has the youth had to repeat grades?	☐ Yes ☐ No
Has the youth been suspended or expelled?	☐ Yes ☐ No

If you answered yes to any question above, please explain:

Mental Health History

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Has the youth seen a psychiatrist? ☐ Yes ☐ No			
Psychiatrist Name:	Location:	When? (month/year)	How long?
Has the youth seen a therapist? ☐ Yes ☐ No			
Therapist Name:	Location:	When? (month/year)	How long?
Reason for Therapy: Has the youth ever been hospitalized for psychiatric reasons (including residential or day treatment programs including any alcohol and drug treatment programs? ☐ Yes ☐ No			
Where:	When:	Length of Stay:	
Type of Treatment:	Diagnosis:		
Does the youth currently take psychiatric medications? ☐ Yes ☐ No			

Name:	Dosage:	When prescribed:	Prescribed by:	Response:

Describe any history of the youth's substance use (if applicable):

Developmental History

At what age did the youth achieve the following milestones:

Language (first using words, sentences, etc.)?

Fine Motor Skills (building towers with cubes, drawing circles)?

Gross Motor Skills (rolling over, standing, walking)?

Toilet Training?

Has your youth experienced any regression? ☐ Yes ☐ No If any, please explain.

Family Mental Health History

Does anyone in the family (parents, siblings, aunts, uncles, grandparents, cousins) have a history of:

☐ Depression	☐ Anxiety/Panic	☐ ADHD	☐ Bipolar Disorder	☐ Schizophrenia
☐ Substance Abuse	☐ Learning Disability	☐ OCD	☐ PTSD	☐ Completed Suicide
☐ Autism Spectrum Disorder		☐ Other:		

If yes, what relative?

Medical History

Does the youth receive routine medical care?

Please list any medical conditions:

Describe any serious accident, illness or injury the youth has had and at what age:

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Additional Information
Please tell us anything else you think will help us understand the youth, include any questions you would like us to answer:

988 Suicide & Crisis Lifeline

People can call or text **988** or chat **988lifeline.org** for themselves or if they are worried about a loved one who may need crisis support.

988 serves as a universal entry point so that no matter where you live in the United States, you can reach a trained crisis counselor who can help.

988 offers 24/7 access to trained crisis counselors who can help people experiencing mental health-related distress. That could be:

- Thoughts of suicide
- Mental health or substance use crisis, or
- Any other kind of emotion distress

988 SUICIDE & CRISIS LIFELINE

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