January 2014

FINANCIAL AGREEMENT FOR:

_____

90834 + 90785 Interactive Individual Psychotherapy
_____
45-50 minutes

90837 + 90785 Interactive Individual Psychotherapy
_____
75-80 minutes

90832 + 90785 Interactive Individual Psychotherapy
_____
20-30 minutes

90834 Individual Psychotherapy _____
40-50 minutes

90832 Individual Psychotherapy _____
20-30 minutes

90847 Family Psychotherapy _____

90849 Multiple-family Group Psychotherapy _____

90853 Interactive Group Psychotherapy _____

90791 Initial Diagnostic Interview _____

90791 + 90785 Interactive Diagnostic Interview
_____

I understand I am committing myself to be regular and punctual in meeting my appointments. The time is reserved for me whether I come or not, therefore, I understand the responsibility of paying the agreed amount until such time as the contract is modified or cancelled by agreement between me and the counselor. All sums due under the financial agreement are payable in Keller, Texas.

SIGNATURE _____ DATE _____ / _____ /_____

_____
Victory Therapy Center

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above-named agency to release any information requested by attorneys, physicians, insurance companies, employers,

health care providers, or any other entity, which may be concerned with payment of the charges incurred at Victory Therapy Center.

_____ DATE _____ /_____ /

_____ Client (Parent or Guardian if a Minor)

Participant Informed Consent & Voluntary Release Form

DISCLOSURE

At Victory Therapy Center, safety is our number one priority in the facilitation and management of all levels of programming; however, even with the adherence to recognized risk management practices in adventure programming and horse-related activities, accidents do occur. The level of participation in our programs is entirely voluntary

Victory Therapy Center programs and training involve a variety of activities including warm ups, discussion/ debriefing, games, group initiatives (physical and cognitive), low challenge course elements (6-50 inches), horse-related activities, and other potentially rigorous physical/emotional activities. The inherent risks and other risks of this program are not unlike other physically and emotionally demanding activities and may include falls, heat stroke, hypothermia, anxiety and other fear responses, elevated heart rates, collisions with objects or other people, unsafe acts by other participants, acts of nature related to being in outdoor venues, and other risks that may be noted by participants and staff.

VOLUNTARY RELEASE OF LIABILITY

I am over 18 years of age. I assume full responsibility for myself and/or my minor children for all risks, inherent and otherwise, related to attendance and participation in this program sponsored by Victory Therapy Center. By signing this release form, I agree to release and hold harmless Victory Therapy Center, their agents, assistants, employees, facilitators, all individuals assisting in instructing and conducting these activities, and co-sponsors including but not limited to their employees or agents, all shareholders, officers, directors of the corporation (collectively known as Releasees), for any damage or injuries, physical or mental, which I and/or my minor children might incur as a result of my voluntary decision to participate. By signing this release form, I agree that if I do sustain any physical injury or mental damage of any nature as a result of my voluntary decision to participate in the program. On behalf of myself, my children, my heirs, personal representatives and next of kin, I hereby release and discharge Releasees and their successors, assigns, affiliates, directors, officers, employees and agents from any and all liabilities, claims, lawsuits, losses, costs, causes of action and damages of any kind originating or in any way arising from my or my children's participation in activities (Even if such claim is due in whole or in part to the negligence of releasees and their successors, assigns, affiliates, directors, officers, employees and agents.) The foregoing release includes a release of releasees and their successors, assigns, affiliates, directors, officers, employees and agents for their own negligence. In the event that any of my children, guests, or other third person shall assert any claims of whatsoever kind against the Releasees, their successors, assigns, affiliates, directors, officers, employees and agents, arising out of or related in whole or in part to any negligent act or omission by me in connection with program activities, I agree to indemnify and hold harmless the Releasees, their successors, assigns, affiliates, directors, officers, employees and agents from such claims and any related liabilities, obligations and expenses, including attorneys' fees and other costs of investigation and litigation.

I assume full responsibility for myself and/or my minor children and guests for bodily injury, death, loss of personal property, and expenses thereof, as a result of my negligence, or other risks, including but not limited to those related to participation in any aspect of this program for the full duration of my participation in this program.

I acknowledge that I have been given the opportunity to ask questions regarding any aspect of this release form and by signing in the space provided do acknowledge that I have read completely and fully understand all aspects of this release form and agree to its terms in their entirety. I have been informed of the full nature of this program and its inherent risk and fully understand the nature of the program.

_____

_____

Participant Signature Date

MEDICAL INFORMATION

If I and/or my minor children do voluntarily choose to participate in programs or other workshop sponsored by Victory Therapy Center, I recognize that there is a significant element of risk in any adventure, sport or activity associated with outdoors, which may involve horse-related activities. Knowing the inherent risk, dangers and rigors involved in the activities, I certify that I and/or my minor children are fully capable of participating in the activities.

I disclose the following medical information so that Victory Therapy Center facilitators and staff are properly informed. (Please indicate N/A if not applicable)

I am currently under a doctor's care for:

_____

_____

_____

_____

I am currently taking the following medication(s) (Please list any side effects which might affect your participation):

_____

_____

_____

_____

I am allergic to the following medications(s) or allergen(s), such as food, insect bites, poison ivy, etc. (Please bring medications for asthma or allergies with dosage marked with you, i.e. inhaler, epinephrine):

_____

_____

_____

_____

The following condition(s) might affect my participation:

_____

_____

_____

_____

By signing this release form, I assume full responsibility for all risks, inherent and other, related to my attendance and participation in this program sponsored by Victory Therapy Center as noted in the Voluntary Release of Liability above. I further consent to first aid, emergency care and, if necessary, admission to an accredited hospital for treatment of injuries that I may sustain while participating in any activity associated with Victory Therapy Center.

PLEASE SIGN

_____

_____
Participant Signature Date

_____

_____ Participant Name (print)

_____

_____
Address City Zip

_____

_____
Parent/Guardian (if participant is under 18 years of age)

PARENT OR GUARDIAN AUTHORIZATION : In the event I cannot be reached in an EMERGENCY, I hereby give my consent to hospitalize and or secure treatment for my minor child.

_____

_____
Parent/Guardian Signature Phone

_____

_____
Physician Name Phone

Additionally, I grant to Victory Therapy Center and persons acting for or through them, the rights to use, reproduce, assign and/or distribute photographs, films, videotapes, and sound recordings of myself for use in marketing or education materials they may create.

I agree _____ decline _____ to release photo/media to Victory Therapy Center (please check one).

VICTORY THERAPY CENTER

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize to: Victory Therapy Center to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client record upon request to the authorized individual or agency involved in the medical emergency treatment.

Physician's Name:

_____

_____

Preferred Medical Facility:

_____

_____

Insurance:

_____

_____

Designated Person: _____ Phone:

_____

CONSENT PLAN

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Consent Signature: _____ Date: _____/

_____/_____ Client (parent or guardian if minor client)

Print Name: _____ Phone:

_____

NON-CONSENT PLAN

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____

_____

_____

_____

_____

_____

Non-Consent Signature: _____ Date: _____/

_____/_____

Client (parent or guardian if minor client)

Print Name: _____ Phone:

UNDER TEXAS LAW (CHAPTER 87, CIVIL PRACTICE AND REMEDIES CODE), AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES.

HIPPA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice of Privacy Practices describes how we may use and disclose you protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist’s practice as necessary, and any other use required by law.

Treatment: We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to insure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or a higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your therapist’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapists associated with this practice, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to graduate students who see clients at our facility. In addition, we may call you by name in the waiting room when the therapist is ready to see you.
We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use or disclose your protected health information in the following situations without your authorization: communicable diseases, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a treat to yourself or to others.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization and opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

I acknowledge that I have received and understood the HIPPA Notice of Privacy Practices for this agency:

_____

Client Signature (parent or guardian if minor client) Date

Consent for Use and Disclosure of Health Information:
I hereby permit and release Victory Therapy Center to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMOs, PPOs, managed care organizations, IPAs, or other governmental or third party payers, or any organization contracting with any of the above entities to perform such functions.

Client Signature (parent or guardian if minor client) Date

You have the right to request restrictions of uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent.

CHILD PSYCHOSOCIAL QUESTIONNAIRE
VICTORY THERAPY CENTER
January 2014

ALL INFORMATION REPORTED IN THIS QUESTIONNAIRE IS KEPT STRICTLY CONFIDENTIAL

Child's Name (Last, First, M.I.):		❑ M ❑ F	
Address:	City:	State:	Zip:
Date of birth:	Gender:	Ethnicity:	

Parent/Guardian Name(s):	
Home phone:	Parent Cell phone:
Parent Work phone:	Other:

Who referred you to us?

Briefly describe the concern or problem for which you are seeking counseling or other services:

_____

_____

_____

_____

_____

How long has this been a concern?

How severe would you say this issue or problem is? ❑ Mild ❑ Moderate ❑ Severe ❑ Unbearable

EMERGENCY CONTACT

Name:	Phone:	Relationship:

MENTAL HEALTH HISTORY

Has your child ever been evaluated by a mental health professional?	❑ Yes ❑ No	
If yes, when?	Diagnosis:	
Has your child been prescribed medication for a mental health condition?	❑ Yes	❑ No
Is your child currently taking medication for a mental health condition?	❑ Yes	❑ No
Have they ever taken medication for a mental health condition in the past?	❑ Yes	❑ No
Is your child currently receiving any counseling or mental health services?	❑ Yes	❑ No
Have they ever been hospitalized for psychiatric services?	❑ Yes	❑ No

Have they received counseling in the past? ❑ Yes ❑ No Provider's name:

If yes, was it helpful? ❑ Yes ❑ No

Has your child ever harmed his/her self intentionally in any way? ❑ Yes ❑ No

Have they ever talked about committing suicide? ❑ Yes ❑ No

Has your child ever attempted suicide? ❑ Yes ❑ No

If yes to any of the above three questions, please briefly explain:

To your knowledge, are they having thoughts of harming his/her self now? ❑ Yes ❑ No

Has your child ever reported thoughts of harming someone else? ❑ Yes ❑ No

If yes to any of the two questions above, please briefly explain:

TRAUMA HISTORY

Has your child ever experienced or witnessed: ❑ Physical Abuse ❑ Sexual Abuse/Sexual Assault ❑ Emotional Abuse

If yes to any, please explain:

Has your child had a traumatic event occur in his/her life within the past year? ❑ Yes ❑ No

Briefly describe any and all events:

Please list any other traumatic event:

Has your child experienced separation from or loss of a loved one in the past year? If so, please briefly explain:

FAMILY RELATIONSHIP AND LIVING ARRANGEMENTS

Who lives in the child's home?

Do they have any siblings not living in the home?

Is your child satisfied with his/her current living situation? ❑ Yes ❑ No

How satisfying is your relationship with your child? ❑ Very ❑ Somewhat ❑ Not at all

What would you say is your child's biggest source of stress?

What else is stressful or worrisome for your child currently?

Who is your child closest to (family, friends, partner, etc.)?

Has your child lived with you since birth? If no, please explain. ❑ Yes ❑ No

Do you currently have relationships with extended family members (parents, grandparents, siblings, etc.)? ❑ Yes ❑ No

EDUCATION

What concerns do you have regarding your child's education or performance in school?

Does your child enjoy school? ❑ Very much ❑ Somewhat ❑ Not at all

SOCIAL/RECREATION

What does your child do for fun?

How many times in the past month would you say your child had fun? ❑ 0 ❑ 1-3 ❑ 4-9 ❑ 10+

What interests your child?

What is your child good at doing?

What do they wish you were good at doing?

How many close friends do they have?

Would you say your child's friends are a positive or negative influence?

How would you describe your child? ❑ Shy ❑ Outgoing ❑ Somewhere in between

What sort of activities do you engage in with your child?

SPIRITUALITY AND RELIGION

Does your child believe in God or a Higher Power? ❑ Yes ❑ No

Do you consider religion to be an important part of your family life? ❑ Yes ❑ No

Do you attend church? ❑ Yes ❑ No

MEDICAL HISTORY

ALL QUESTIONS IN THIS SECTION ARE OPTIONAL AND ARE KEPT STRICTLY CONFIDENTIAL

Does your child have any significant current or past medical problems?

Surgeries/Hospitalizations

Year	Reason	Treatment

List any prescribed medications

Name of Medication	Dosage	Frequency Taken

FAMILY MENTAL HEALTH HISTORY

Relative		AGE	Any mental health issues or substance abuse problems?	Relative	AGE	Any mental health issues or substance abuse problems?
Father				**Grandmother (maternal)**		
Mother				**Grandfather (maternal)**		
Sibling	❑ M ❑ F			**Grandmother (paternal)**		
	❑ M ❑ F			**Grandfather (paternal)**		
	❑ M ❑ F			**Other:**		
	❑ M ❑ F					
	❑ M ❑ F					
	❑ M ❑ F					

VICTORY THERAPY CENTER
vtc

Equine Assisted Psychotherapy

Victory Therapy Center offers Equine Assisted Psychotherapy (EAP), an emerging therapeutic intervention used in a variety of mental health settings, particularly in the treatment of children, adolescents, and veterans. It is a type of recreational and adventure-based therapy loosely related to animal-assisted therapy. It combines traditional therapeutic interventions with a more innovative component involving relationships and activities with horses. **Through EAP individuals can address and alter maladaptive coping strategies and behaviors in a new and challenging environment, which positively affects their psychosocial functioning outside of the therapeutic setting.**

EAP is guided by treatment plans and diagnoses, and is facilitated by qualified mental health professional and equine professional. The horse professional is primarily responsible for safety and for observing the behavior of the horse, because **the horse's reaction to the client is as powerful as the client's response to the horse.** The mental health professional is primarily responsible for the therapeutic aspects of session.

While horse knowledge may be gained during EAP, it is not the main goal. **EAP is not horsemanship, it is "lifemanship."** The focus is on the *process* of participating in an activity with horses, and the client's behavior and response is central. The experiential aspect of EAP allows client's behaviors and emotions to surface in a way that traditional talk therapy does not allow. **Interventions involving activities with horses can help children, individuals and families traverse chaotic life circumstances and give them a paradigm for success and positive peer interactions.**

Victory Therapy Center
10600 Dunham Rd, Roanoke, TX 76262

682-831-1323-o; 682-831-1362-f
www.victorytherapy.org
January 2014

PSYCHOSOCIAL QUESTIONNAIRE
VICTORY THERAPY CENTER
(Jan 2014)

ALL INFORMATION REPORTED IN THIS QUESTIONNAIRE IS KEPT STRICTLY CONFIDENTIAL

Name (Last, First, M.I.): ❑ M ❑ F			MOS/Title:
Parent/Guardian Name(s):			
Address:	City:	State:	Zip:
Date of birth:	Gender:	Ethnicity:	
Home phone:	Cell phone:	Work phone:	
Marital status: ❑ Single ❑ Partnered ❑ Married ❑ Separated ❑ Divorced ❑ Widowed			
Military status: ❑ Active ❑ Separated ❑ Reserve ❑ Retired ❑ Family Member	Branch: Rank:	Entry Date:	Do you have your DD214 or copy of orders?
Who referred you to us?			

Briefly describe the concern or problem for which you are seeking counseling or other services:

_____

_____

_____

_____

_____

How long has this been a concern for you?

How severe would you say this issue or problem is? ❑ Mild ❑ Moderate ❑ Severe ❑ Unbearable

EMERGENCY CONTACT

Name:	Phone:	Relationship:

MENTAL HEALTH HISTORY

Have you ever been evaluated by a mental health professional?	❑ Yes	❑ No
If yes, when? Diagnosis:		
Have you been prescribed medication for a mental health condition?	❑ Yes	❑ No
Are you currently taking medication for a mental health condition?	❑ Yes	❑ No
Have you ever taken medication for a mental health condition in the past?	❑ Yes	❑ No
Are you currently receiving any counseling or mental health services?	❑ Yes	❑ No
Have you ever been hospitalized for psychiatric services?	❑ Yes	❑ No

Have you received counseling in the past? ❑ Yes ❑ No Provider's name:

If yes, was it helpful? ❑ Yes ❑ No

Have you ever harmed yourself intentionally in any way? ❑ Yes ❑ No

Have you ever considered committing suicide? ❑ Yes ❑ No

Have you ever attempted suicide? ❑ Yes ❑ No

If yes to any of the above three questions, please briefly explain:

Are you having any thoughts of harming yourself now? ❑ Yes ❑ No

Do you now or have you recently had thoughts of harming someone else? ❑ Yes ❑ No

If yes to any of the two questions above, please briefly explain:

TRAUMA HISTORY

Have you ever experienced or witnessed: ❑ Physical Abuse ❑ Sexual Abuse/Sexual Assault ❑ Emotional Abuse

If yes to any, please explain:

Have you had a traumatic event occur in your life within the past year? ❑ Yes ❑ No

Briefly describe any and all events:

Were you involved in any blasts, explosions, IED's, mortars, rockets, etc.? ❑ Yes ❑ No

If yes, how many? ❑ 1-5 ❑ 6-10 ❑ 11+

Have you experienced any combat-related stress? ❑ Yes ❑ No
Briefly describe:

Please list any other traumatic events in your past:

Have you experienced separation from or loss of a loved one in the past year? If so, please briefly explain:

FAMILY RELATIONSHIP AND LIVING ARRANGEMENTS

Who lives in your home with you?

Do you have any children not living with you?

Are you satisfied with your current living situation? ❑ Yes ❑ No

Do you consider your home a safe place to live? ❑ Yes ❑ No

How long have you been with your partner/spouse?

How satisfying is this relationship for you? ❑ Very ❑ Somewhat ❑ Not at all

What would you say is currently your biggest source of stress?

What else is stressful or worrisome for you currently?

Who are you closest to (family, friends, partner, etc.)?

Who raised you during childhood and adolescence?

Do you currently have relationships with extended family members (parents, grandparents, siblings, etc.)? ❑ Yes ❑ No

EDUCATION AND WORK

What was the highest education you've completed?

❑ Elementary School ❑ Middle School ❑ High School
❑ Trade School ❑ Some college ❑ Undergraduate degree
❑ Graduate degree ❑ Military School/Training

Are you currently employed? ❑ Yes ❑ No

If yes, where?

How satisfying is your current employment situation? ❑ Very ❑ Somewhat ❑ Not at all

SOCIAL/RECREATION

What do you do for fun?

How many times in the past month would you say you have had fun? ❑ 0 ❑ 1-3 ❑ 4-9 ❑ 10+

What interests you?

What are you good at doing?

What do you wish you were good at doing?

How many close friends do you have?

Would you say your friends are a positive or negative influence?

How would you describe yourself? ❑ Shy ❑ Outgoing ❑ Somewhere in between

How satisfied are you with the quality and amount of friendships you have? ❑ Very ❑ Somewhat ❑ Not at all

What sort of activities do you engage in with your partner/spouse?

SPIRITUALITY AND RELIGION

Do you believe in God or a Higher Power? ❑ Yes ❑ No

Do you consider religion to be an important part of your life? ❑ Yes ❑ No

Do you attend church? ❑ Yes ❑ No

MEDICAL HISTORY

ALL QUESTIONS IN THIS SECTION ARE OPTIONAL AND ARE KEPT STRICTLY CONFIDENTIAL

Do you have any significant current or past medical problems?

Have you been told by a physician that you have a Traumatic Brain Injury?

Please describe any head injuries you have sustained including impacts/vibrations to the head. Please describe the treatment you received.

Surgeries/Hospitalizations

Year	Reason	Treatment

List your prescribed medications

Name of Medication	Dosage	Frequency Taken

HEALTH HABITS AND PERSONAL SAFETY

Exercise	❑ Sedentary (no exercise) ❑ Mild exercise (i.e. climb stairs, walk 3 blocks, golf) ❑ Occasional vigorous exercise (i.e. work or recreation, less than 4x/week for 30 min) ❑ Regular vigorous exercise (i.e. work and recreation 4x/week for 30 minutes)
Caffeine	❑ None ❑ Coffee ❑ Tea Number of cups or cans per day?
Alcohol	Do you drink alcohol? ❑ Yes ❑ No
	If yes, what kind?
	How many drinks per week?
	Are you concerned about the amount you drink? ❑ Yes ❑ No
	Have you considered stopping? ❑ Yes ❑ No
	Have family/friends ever been concerned about the amount you drink? ❑ Yes ❑ No
	Have you ever experience blackouts? ❑ Yes ❑ No
	Are you prone to “binge” drinking? ❑ Yes ❑ No
	Do you drive after drinking? ❑ Yes ❑ No
Drugs	Do you currently use recreational or street drugs? ❑ Yes ❑ No
	Have you ever given yourself street drugs with a needle? ❑ Yes ❑ No

Tobacco	Do you smoke or use tobacco? ❑ Yes ❑ No
	❑ Cigarettes – packs/day: _____ ❑ Chew - #/day: _____ ❑ Pipe - #/day: _____ Age at first use: _____ Age at first use: _____ Age at first use: _____
Yes	Have family/friends ever been concerned about the amount you smoke or use tobacco per day? ❑ ❑ No
	Have you ever made an attempt to quit? ❑ Yes ❑ No
	Has the amount of smoking or using tobacco ever been a concern for you? ❑ Yes ❑ No
Sex	Are you sexually active? ❑ Yes ❑ No
	How many different sexual partners have you had in the last year?
Personal Safety	Do you live alone? ❑ Yes ❑ No
	Have you engaged in any behavior that poses a serious risk to your wellbeing? ❑ Yes ❑ No
	Do you have vision or hearing loss? ❑ Yes ❑ No
	Physical and/or mental abuse has also become a major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this with your provider? ❑ Yes ❑ No

FAMILY MENTAL HEALTH HISTORY

		AGE	Any mental health issues or substance abuse problems?			AGE	Any mental health issues or substance abuse problems?
Father				**Children**	❑ M		
Mother					❑ F ❑ M		
Sibling	❑ M ❑ F				❑ F		
	❑ M ❑ F				❑ M		
	❑ M ❑ F			**Grandmother** Maternal			
	❑ M ❑ F			**Grandfather** Maternal			
	❑ M ❑ F			**Grandmother** Paternal			
	❑ M ❑ F			**Grandfather** Paternal			
				Other:			