evolve
Behavioral Health Services
and Medication Management

Phone: 800-409-6250 Fax: 479-437-3708

Dear patient,

This letter serves to introduce ourselves as your behavioral health care management team and as your review of consent information. When utilizing behavioral health services, you want to ensure that the organization and providers you have chosen have the knowledge, training, and experience to get the best results for you. Evolve Behavioral Health Services strives to maintain a team of behavioral healthcare professionals who go above and beyond to provide quality care to our patients.

We take a collaborative and supportive stance in our approach to treatment with a team that is composed of Behavioral Health Case Coordinators, Licensed Certified Social Workers, Licensed Professional Counselors, Licensed Practical Nurses, and Board Certified Psychiatric Mental Health Nurse Practitioners that will work with your Healthy Connections primary care provider to provide the highest quality of care possible for our patients. This means that at times we may need to discuss certain information with your treatment team such as medication side effects, symptoms, diagnosis, and treatment goals and objectives. We want to assure you that personal details you share within your sessions are not shared as part of the treatment team process due to your right to confidentiality.

Confidentiality is your right to keep private the information shared by you within the behavioral health process. It will not be released to any other individuals or agencies without your written consent. It is important that you know that your information is not shared except within certain special circumstances which include: when required by law (legal subpoena); when documents are needed to comply with insurance policies for payment; under situation deemed potentially life threatening to yourself or others; and in situations involving abuse and/or neglect of children, elderly, or disabled persons.

The successful achievement of your behavioral healthcare goals is dependent upon attending your appointments, both for therapy and for medication management. Due to a high volume of patients needing behavioral healthcare services it is imperative that we have a clear, consistent no show policy. Our no show policy here at Evolve is as follows: a patient who no shows a new therapy or medication management intake will need a new referral from their provider to be rescheduled; an existing patient who no shows a therapy or medication management appointment can have any future appointments cancelled and may not be rescheduled. We know this policy is strict but it is also necessary to ensure that our patient care schedules are optimized to provide services to those patients who are committed to their treatment goals. We encourage you to reach out to one of our Behavioral Health Case Coordinators on our Evolve phone line if you need to cancel and/or reschedule your appointment or if you have encountered extenuating circumstances that have lead to a no show. We will make every effort to help you make another appointment that fits with your schedule.

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We will strive to provide you the highest quality services, to assist you in as respectful and efficient a manner as possible, to maintain professional behavior consistent with ethics of our profession, and to work as briefly as you will allow to achieve your treatment goals. The length of services needed for each patient varies depending upon needs and participation. Behavioral health services such as therapy and medication management have many benefits such as promoting positive change and growth. There can also be risks associated with these services such as distress from resurfacing memories, high levels of emotion or unexpected physical sensations, flashbacks, dreams, and symptoms or feelings that get worse before improving. These memories and emotions may be unwanted or feel uncomfortable but patients that experience these still have every capability of healing and growing through this process. If it is ever evident that your provider does not possess the expertise necessary to assist you, or if for other reasons progress is not evident we can pursue any of the following strategies: evaluate the possible blockages to progress and develop an alternative therapeutic approach, refer you to another provider, or terminate services.

If you choose to participate in psychiatric medication management it is imperative that you agree to see only one psychiatric medication provider. Our providers cannot ensure that you are receiving the medications that will provide you with optimum results if you are receiving medications from other providers. It is the patient's responsibility to inform their medication management provider of any psychiatric medications they are receiving from other providers. If you experience any side effects and/or adverse reactions to medications prescribed while under our care please contact the behavioral health nurse that is working with your medication management provider. It is the patient's responsibility to call our Evolve patient care team, either BH Case Coordinator or BH Nurse, when refills are needed for your medications. To ensure that you receive your refills as needed please call at least a week in advance.

Welcome to Evolve Behavioral Health Services at Healthy Connections Incorporated, we look forward to serving you!

I attest that I have read and understand this information. I also verify that if signing this consent as the parent/legal guardian of a minor, that I am legally authorized to do so.

_____ _____

Patient or Parent/Legal Guardian Date

Healthy Connections
Community Health Network
Medical • Dental • Behavioral Health • Outreach

HEALTHY CONNECTIONS: CHILD BEHAVIORAL HEALTH CONSULT SCREENING INFORMATION <12yrs old

Name: _____ **Date of Birth:** _____

Who referred you for treatment: _____

Presenting Concerns: _____

_____

When did symptoms first start? _____

List current medications with dosage: _____

_____

List previous psychiatric medications: _____

_____

Primary Care Physician (PCP): _____

Allergic to anything: YES NO if so list: _____

PLEASE CIRCLE ANY OF THE FOLLOWING AND FILL IN ANY BLANKS THAT APPLY

Education: Current Grade_____ Alternative School Placement Home Schooled Special Education

GED Pre-AP/AP/IB classes 504 Plan/IEP Learning Disorder Advanced/Gifted Grade Failures ____

School behavior problems Social Anxiety Inattention/Unfocused Bullied/Teased Aggressive/bully

Frequent suspensions/ISS Reasons for suspensions:_____

Home Environment

Parent's marital status: Married Never Married Divorced Widowed Remarried Single

Adopted: Details_____

Foster Parent: Details_____

Name of Household Members:

Name: Age Relationship

1)

2)

3)

4)

5)

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Home type: Apartment Mobile House Homeless Duplex Hotel/Motel Lives with friends/family

Years in home: _____ Number of moves in the last 5 years: _____

PLEASE CIRCLE THE FOLLOWING THAT CURRENTLY APPLY:

Depression:

Sad Feeling of hopelessness Loss of interest in Activities Irritability

Crying Spells Feelings of helplessness Feelings of worthlessness Weight gain/loss

Thoughts of hurting self Cutting/Self-harm Moodiness Excessively tired

Negative self talk Low self-esteem

Suicidal Thoughts:

None Thoughts that life is not worth living Thoughts of hurting self

Plans to hurt self Previous attempt to harm self Date of last attempt_____

Homicidal Thoughts:

None Thoughts of harming others Plans to harm others

Previous attempts at harming others Date of last attempt_____

Sleep Disturbance:

Sleeps well Wakes Frequently Trouble falling asleep Sleep apnea

Sleeps w/caregiver Hours slept per night_____ Afraid of dark Wanders at night

Sleep walks

Anxiety:

None Anxious Worries A Lot Panic Attacks Trouble leaving home

Seperation Anxiety Phobias Social Anxiety

Post-Traumatic Stress Symptoms:

None Flashbacks Nightmares Startle Response Phobias

Guilt Withdrawing Spacing out Sleep Disturbance Irritability

Feeling Numb Panic Attacks Social Withdraw

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Traumatic/Abusive Experiences:

None	Physical Abuse	Exposure to Domestic Violence	Exposure to Violence
Neglect	Verbal Abuse	Childhood Sexual Abuse	Emotional Abuse
Bullied	Sexual Assault	Separation from Parent or Caregiver	
Foster Care/Residential Treatment		Extreme Poverty	Homelessness
Natural Disasters		Prison	Military Combat
Head Injury/TBI Chronic/Life		Threatening Illness	Car Accidents
Attacked By Animal		Serious Accidents or Falls	Near drowning
Divorce/Abandonment		Significant losses	Mugged/Robbed
Parental Substance Abuse		Parental Mental Illness	Parental Imprisonment
Multiple Surgeries		Other (please explain):_____	

Was abuse reported to police, hotline, or CPS? Yes No

If yes, when?

Is the case still open?

Impulsivity and hyperactivity:

Impulsive/hyperactive	Often interrupts	Difficulty waiting turn	Blurts out answers
Restless	Talks Excessively	Fidgets and Squirms	Excitable
On the go	Destructive		

Attention and Concentration:

Alert	Focused	Easily Distracted	Disorganized	Errors	Preoccupied
Forgetful	Careless Mistakes				

Oppositional Behaviors:

Biting	Head Banging	Physical Aggression	Tantrums	Verbal Aggression
Yelling	Oppositional to Adults	Defiant	Spiteful	Disrespectful
Bully to Others	Drug Use	Sneaking out	Run Away	Lying
Manipulative	Disregard for safety of self/others		Extreme sibling/parent/teacher/peer conflict	

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Substance Abuse:

None Alcohol Marijuana Sedatives Nicotine Synthetic Marijuana/Bath Salts

Other: _____

Treatment received: _____

Family History of Substance Abuse:

Mother Father Sibling Stepparents Grandparents Aunts Uncles

Family Psychiatric History:

None Unknown Depression Anxiety PTSD ADHD Schizophrenia Obsessive-compulsive

Eating Disorder Bipolar Disorder Personality Disorder History of Sexual Abuse/Assault

History of Physical Abuse/Domestic Violence Suicidal Idation/Attempts/Completion

Treatment or Counseling History:

No Previous Psychiatric Care No Previous Counseling or Therapy

Previous Psychiatric Evaluation/Treatment Dates: _____ Doctor/Agency: _____

Previous Counselor/Therapist Dates: _____ Therapist/Agency: _____

Previous psychiatric hospitalizations: Dates: _____ Hospital: _____

PLEASE CIRCLE ANY OF THE FOLLOWING AND FILL IN ANY BLANKS THAT APPLY

Birth History:

Unknown Birth Weight ____lbs____oz Full term Premature C-Section

Drug/Alcohol use during pregnancy Placed in foster care Adopted Emotional Stress during pregnancy

Complications during pregnancy:_____

Birth Order _____ of _____.

Surgeries or Medical Issues:_____

Developmental History:

Unknown	No Concerns Reported	Chronic/Multiple Illness
Speech/Language Delay	Multiple Injuries	Feeding Problems
"Difficult Child"	Colic	Late Walker
Developmental Delays	Head Injury	Bladder/Bowel Control Problems

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Medical History/Conditions:

Head Injury	Diabetes	Asthma	Headaches
Anemia	Tumors/Cancer	Heart Trouble	Bedwetting/Soiling Issues
Chronic Fatigue	Dizziness/Fainting	Kidney Disease	High Blood Pressure
Speech/Language/Hearing Issues		Seizures	

Other Medical Conditions or Surgeries: _____

Nutritional Screening:

Normal	Appetite Disturbance	Food Allergies_____	Eating Issues
Food Hoarding	Overweight	Underweight	Chewing/Swallowing

Pain and Comfort:

No Current Pain	Current Physical Pain	Chronic Pain: Constant	Sharp Dull Burning
Stabbing	Takes Pain Medication	Has had Surgery	Completed Physical Therapy

Sexuality

Sexually Active	Not sexually active		
Heterosexual	Homosexual	Bisexual	Pansexual
Sexual Abuse	High risk sexual behavior	Sexual Identity Concerns	Gender Identity Concerns
HIV	History of STD's		

Leisure Activities/Hobbies: _____

What changes would you like to see with treatment? _____

_____

What is your goal for your child? _____

_____

What will successful treatment look like to you? _____

_____

Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

		Never	Sometimes	Often
1. Complains of aches and pains	1			
2. Spends more time alone	2			
3. Tires easily, has little energy	3			
4. Fidgety, unable to sit still	4			
5. Has trouble with teacher	5			
6. Less interested in school	6			
7. Acts as if driven by a motor	7			
8. Daydreams too much	8			
9. Distracted easily	9			
10. Is afraid of new situations	10			
11. Feels sad, unhappy	11			
12. Is irritable, angry	12			
13. Feels hopeless	13			
14. Has trouble concentrating	14			
15. Less interested in friends	15			
16. Fights with other children	16			
17. Absent from school	17			
18. School grades dropping	18			
19. Is down on him or herself	19			
20. Visits the doctor with doctor finding nothing wrong	20			
21. Has trouble sleeping	21			
22. Worries a lot	22			
23. Wants to be with you more than before	23			
24. Feels he or she is bad	24			
25. Takes unnecessary risks	25			
26. Gets hurt frequently	26			
27. Seems to be having less fun	27			
28. Acts younger than children his or her age	28			
29. Does not listen to rules	29			
30. Does not show feelings	30			
31. Does not understand other people's feelings	31			
32. Teases others	32			
33. Blames others for his or her troubles	33			
34. Takes things that do not belong to him or her	34			
35. Refuses to share	35			

Total score _____

Does your child have any emotional or behavioral problems for which she or he needs help? ( ) N ( ) Y

Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services?_____

Pediatric Symptom Checklist—Youth Report (Y-PSC)

Please mark under the heading that best fits you:

		Never	Sometimes	Often
1. Complain of aches or pains	1			
2. Spend more time alone	2			
3. Tire easily, little energy	3			
4. Fidgety, unable to sit still	4			
5. Have trouble with teacher	5			
6. Less interested in school	6			
7. Act as if driven by motor	7			
8. Daydream too much	8			
9. Distract easily	9			
10. Are afraid of new situations	10			
11. Feel sad, unhappy	11			
12. Are irritable, angry	12			
13. Feel hopeless	13			
14. Have trouble concentrating	14			
15. Less interested in friends	15			
16. Fight with other children	16			
17. Absent from school	17			
18. School grades dropping	18			
19. Down on yourself	19			
20. Visit doctor with doctor finding nothing wrong	20			
21. Have trouble sleeping	21			
22. Worry a lot	22			
23. Want to be with parent more than before	23			
24. Feel that you are bad	24			
25. Take unnecessary risks	25			
26. Get hurt frequently	26			
27. Seem to be having less fun	27			
28. Act younger than children your age	28			
29. Do not listen to rules	29			
30. Do not show feelings	30			
31. Do not understand other people's feelings	31			
32. Tease others	32			
33. Blame others for your troubles	33			
34. Take things that do not belong to you	34			
35. Refuse to share	35			