Sage Recovery & Wellness Center

ADOLESCENT REGISTRATION FORM

CLIENT INFORMATION

Legal First & Last Name:	**Preferred name:**	Middle:	
Birth Date:	Age:	Cell phone no.:	Ethnicity:

Sex: ☐ Male ☐ Female ☐ Transgender, Gender Pronoun __________________ ☐ Other, Gender Pronoun __________________

Address:	City:	State:	Zip Code:
Parent/Legal Guardian First & Last Name:	Relationship to client:	Cell phone #:	Home phone #:
Parent/Legal Guardian First & Last Name:	Relationship to client:	Cell phone #:	Home phone #:

Who can we thank for your referral? Name/Organization:

Other family members seen here:

INSURANCE INFORMATION

(Please fill in this information and then give your insurance card to the receptionist.)

If the client is NOT the person responsible for payments, a Release of Information for Financials and Attendance is required.

Person responsible for payments:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	◯ Yes ◯ No	Is this patient covered by insurance?	◯ Yes ◯ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance: | Other:

Subscriber's name:		Birth date:	Group no.:	Policy no.:	Co-payment:

Patient's relationship to subscriber: | Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: | Other:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Cell or Home phone #.:	Work phone #:

I authorize that the above information is true to the best of my knowledge.

_______________________________________ _______________________

Parent/Legal Guardian Signature Date

Medication Sheet

Medication: Include over the counter and herbal	Dose	Frequency/ time of day taken once daily- 1x, twice daily- 2x, as needed, etc.	Prescribing Physician	*Put your initials under week if there are no changes. Put an "x" if you are no longer taking that medication.*							
				wk 1	*wk 2*	*wk 3*	*wk 4*	*wk 5*	*wk 6*	*wk 7*	*wk 8*
Example: Wellbutrin	100	2x (or twice daily)/1AM & 1PM	Dr. Weatherby	*GR*	*GR*	*GR*	*X*	*X*			

Name: ___________________________ DOB: _______________ Date: _______________

____ ______________

Signature of Medical Director, Cole Weatherby, DO Date

Physical Health Screen

Please check any of the following symptoms you have experienced in the **past 72 hours**.

☐ Muscle tension
☐ Anxiety
☐ Restlessness
☐ Irritability
☐ Insomnia
☐ Headaches/Migraines
☐ Poor concentration
☐ Depression

☐ Social isolation
☐ Sweating
☐ Tremor
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Racing heart
☐ Dizziness
☐ Fainting

☐ **Heart Palpitations**
☐ **Pain/Tightness in the chest**
☐ **Difficulty breathing**
☐ **Confusion**
☐ **Delirium tremens (DTs)**
☐ **Seizures**
☐ **Heart attacks**
☐ **Strokes**
☐ **Hallucinations-visual or auditory**
☐ None

Please check the box indicating any of the following of which you have been diagnosed:

☐ Tuberculosis
☐ HIV/AIDS
☐ STD
☐ Diabetes
☐ Heart disease/attack/condition
☐ Liver problems
☐ Seizure
☐ Hepatitis B or C
☐ Impaired immune system

☐ Stroke
☐ Cancer/Malignancy
☐ Fainting
☐ Blood in vomit or stool
☐ Menstrual Disorders
☐ High/Low BP
☐ Osteopenia/Osteoporosis
☐ Dental problems, specify: ________________________

☐ Hypo/Hyperthyroidism
☐ Polycystic Ovarian Syndrome
☐ Irritable Bowel Syndrome
☐ Fibromyalgia
☐ Chronic Pain
☐ Gastritis
☐ Migraines
☐ Other____________________
☐None

Please check any of the following symptoms or conditions you have experienced in the **past 24 hours**:

☐ Fever or chills
☐ Vomiting or diarrhea
☐ Non-healing wounds or abscess
☐ Wet and/or bloody cough

☐ Any unexplained weight gain or loss in the last 30 days
☐ Any diagnosed infectious illness
☐ None

Any known allergies?____

Have you been seen by a physician in the last 12 months?☐ YES ☐ NO

If applicable: Most recent OBGYN visit: ___________________

Last time had labs/bloodwork done (month/year): __________________________ Results normal? ___________

If not normal, what abnormalities? __________________

Have you experienced any physical discomfort or continuous pain? ☐ YES ☐ NO

If so, please explain:____

Intake Assessment

Please complete this form to the best of your ability. Once you have completed it, please return it to the front desk staff. Check the box for yes or no answers. If che

cked yes, please explain in the space provided.

Do

Adolescent Intake Assessment

Please complete this form to the best of your ability. Once you have completed it, please return it to the front desk staff. Check the box for yes or no answers. If checked yes, please explain in the space provided.

Do you have any cultural, religious, or spiritual beliefs and/or preferences that we should take into consideration for your treatment? ☐ YES ☐ NO Explain:

LEGAL SYSTEM

Have you ever been arrested or gone to court? ☐ YES ☐ NO

Is there a custody agreement in place for you at this time? ☐ YES ☐ NO ☐ N/A

EDUCATION/VOCATIONAL QUESTIONS

What school do you attend?

What grade are you in?

Are you involved in any supportive services (GENaustin, Communities in School, etc.) through school? ☐ YES ☐ NO

Which ones?

Any vocational training or education? ☐ YES ☐ NO

Any learning disabilities? ☐ YES ☐ NO

Do you have a job? ☐ YES ☐ NO

Do you have any issues with your job? ☐ YES ☐ NO

If yes, please explain:

EATING AND EXERCISE HABITS

Do you have any dental problems? ☐ YES ☐ NO

If yes, please explain:

Have you experienced any changes in appetite recently? ☐ YES ☐ NO

If yes, please explain:

Do you ever restrict or avoid particular foods so much that it negatively affects your health or weight? ☐ YES ☐ NO

When considering yourself, is the shape or weight of your body one of the most important things about you? ☐ YES ☐ NO

Have you ever made yourself vomit to control your weight or shape? ☐ YES ☐ NO

Have you ever used laxatives, diet pills or diuretics to control your weight or shape? ☐ YES ☐ NO

Have you gained or lost 10 pounds in the past 3 months? ☐ YES ☐ NO

Do you exercise? ☐ YES ☐ NO

If so, how often and for how long?

SOCIAL/LEISURE ACTIVITIES

Please list the social/leisure activities you enjoy doing. If there is nothing currently, please list activities you enjoyed in the past.

Current:

Past:

HOUSING/ LIVING SITUATION

Who do you live with?

Do you have any concerns/issues in your current environment and living situation? ☐ YES ☐ NO
If yes, please explain:

Anyone in your family diagnosed with a mental health diagnosis? ☐ YES ☐ NO
List their relation to you and type of diagnosis:

Does anyone in your family, past or present or in recovery, have substance abuse or other addictive issues? ☐ YES ☐ NO
List their relation to you and type of addiction:

Have you experienced or are currently experiencing other addictive behaviors like food, pornography, shopping, sex, and/or internet addiction? ☐ YES ☐ NO
If so, please explain:

SUBSTANCE USE ASSESSMENT

******Feel free to skip any and all questions in this section that do not apply to you.***

Have you ever used alcohol, illegal drugs, or prescription drugs that were not prescribed to you or in higher doses than were prescribed?

☐ YES ☐ NO

******If you answered YES to the previous question, please answer the remaining questions in this section. If you answered NO, please feel free to skip to page 7.***

First age of drug or alcohol use:

Last day of alcohol or drug use**:**

If used in the past week, how much and when?

What drugs or alcohol have you been using recently (if any)?

What drugs (if any) did you use in the past that you felt you were using more than just socially?

Longest period of sobriety from all drugs/alcohol?
How many times have you attempted to cut down or stop using (if at all)?

What have you tried in the past when attempting to quit?

Please list relapse history and triggers (if any) that you believe might have led to relapse:

The chart below pertains to specific substances you have used in the past and/or present. Please ***check ONE*** *number under the category that best describes your use pattern. Consider only drugs taken without a prescription from your doctor, unless the prescriptions were/are taken at a higher dosage than prescribed.*

	Age of first use	Date of most recent use	Never used	Tried but quit	Several times a year	Several times a month	Week-ends only	Several times a week	Daily	Several times a day
Alcohol (beer, wine, liquor)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Tobacco (chewing tobacco, dip, snuff, cigarettes, cigars, e-cig)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Cannabis (marijuana, weed, THC)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Cocaine (coke, blow, crack, rock, freebase)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Opioids (heroin, smack, horse, opium, morphine, codeine, hydrocodone, buprenorphine, oxycodone, norco)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Benzodiazepines (valium, Xanax, klonopin, Ativan, Prozac)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Methamphetamine (Speed, amphetamines, methylphenidate-concerta & Ritalin, crystal)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Designer drug (MDMA, Ecstasy, bath salts, K2)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Hallucinogen (LSD, PCP, psilocybin, peyote, ACID, shrooms)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Barbiturates (Quaalude, downers, ludes, blues)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Inhalant/Other (glue,			0	1	2	3	4	5	6	7

gasoline, spray cans, whiteout, rush)			☐	☐	☐	☐	☐	☐	☐	☐

GOALS FOR TREATMENT

What are your short term treatment goals?

What are your long term treatment goals?

Do you have any needs or special requirements for treatment?

Client Printed Name: ____

Client Signature:____ Date: __________________

Questionnaire for Parent/Guardian/Support Person

Is your child subject to a custody court order? ☐ YES ☐ NO

If yes, does the signing parent/guardian have the legal right to EXCLUSIVELY consent to psychological and psychiatric care of the child? ☐YES ☐NO

Is legal right to do so subject to the agreement of the other parent (who is not present)? ☐ **YES** ☐ NO

*****If yes, written documentation is required from the other parent/legal guardian authorizing the child to consent to an assessment and treatment.**

Do you have any concerns in the following areas for your child? If yes, please explain briefly.

Medical issues? ☐YES ☐NO

Emotional issues? ☐YES ☐NO

Cognitive issues? ☐YES ☐NO

Educational issues? ☐YES ☐NO

Nutritional issues? ☐YES ☐NO

Social development issues? ☐YES ☐NO

Motor development issues? ☐YES ☐NO

Delays in developmental functioning/milestones? ☐YES ☐NO

Sensorimotor issues? ☐YES ☐NO

Visual, speech, hearing, and/or language issues? ☐YES ☐NO

Oral health or hygiene? ☐YES ☐NO

Has your child had any surgeries, car accidents, or falls? ☐YES ☐NO

Are there any important family factors that we need to take into consideration when working on a discharge planning?
☐YES ☐NO If so, explain:

PAST TREATMENT

Has your child been diagnosed with a mental health or substance abuse diagnosis? ☐ YES ☐ NO

If yes, what?

Has it changed over time? ☐YES ☐NO

If yes, please explain:

Have they received previous outpatient treatment for mental health and/or substance use (including counseling/psychotherapy and Intensive Outpatient Treatment)? ☐YES ☐NO

Where and when?

Have they received previous inpatient treatment for mental health and/or substance use (including Residential Treatment Center, detox, and Inpatient Psychiatrist hospitalization)? ☐YES☐NO

Where and when?

Did they successfully complete previous treatment? ☐YES ☐NO

If no, explain:

What benefits do you think they received from treatment?

Have they ever been treated for an eating disorder? ☐YES ☐NO

When and where?

Are you working with any other agencies? ☐YES ☐NO

FAMILY HOUSEHOLD ASSESSMENT

Who lives in the home?

Name	Age	Relationship to child

Does anyone in the family or household have substance abuse or other addictive issues, in the past, present or in recovery? ☐YES ☐NO

List their relation to the child and type of addiction:

Anyone in your family diagnosed with a mental health diagnosis? ☐YES☐NO

List their relation to child and type of diagnosis:

Has anyone in the family experienced other addictive behaviors like food, pornography, shopping, sex, and/or internet addiction? ☐YES ☐NO If so, please explain:

Does anyone in the family have any medical issues we should be aware of? ☐YES ☐NO
If so, please explain:

Does anyone in the family or household have any legal issues, past or present, that we should be aware of?
☐YES ☐NO If so, please explain:

Has anyone in the family or any individuals living in the household ever been involved with CPS, APS (Adult Protective Services), or APD (Austin Police Department)? ☐YES ☐NO
If yes, please explain:

Is there anything else about the family or household that we should take into consideration for treatment (cultural or religious beliefs or practices, etc)? ☐YES ☐NO
If so, please explain:

What goals and/or wants do you have for your child for receiving services here?

Are there any other concerns you would like the team working with your child to know about?

Printed Name of Parent or Guardian: ____

Signature of Parent or Guardian: _________________________________ Date: ___________________

Release of Information

Purpose: The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Expiration: Unless sooner revoked, this authorization expires on the 60 days after my last appointment.

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the therapist I am working with at **Sage Recovery & Wellness Center**. I understand that I may revoke this authorization, by requesting in writing, a discontinuation of this document to **7004 Bee Caves Rd, 2-200, Austin, Texas 78746**. I also understand that the written revocation must be signed and dated with a date that is later than the date of this authorization. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

I, ____ (parent/guardian), consent to the release of privileged information for ____________________________ (client) and waive the privilege of confidentiality afforded for medical and mental health care, alcohol and drug rehabilitation, and authorize Sage Recovery & Wellness Center's staff to communicate with the individuals listed below to exchange any information for the purpose of clarifying and enhancing my care and treatment.

Check one or both of the following:

To obtain from ☐ **To disclose to ☐**

Name:__________________________________ Relationship to Client:______________________________

Phone: __________________________________ Fax: ____

**Ask the front desk staff for another copy of this form if you would like to or are required to release privileged information to more than one individual.*

☐ Assessment ☐ Treatment Plans ☐ Letter of Admission	☐ Discharge Summary ☐ Letter of Completion	☐ Urine Analysis ☐ Group Notes ☐ Individual Therapy Notes	☐ Attendance ☐ Financials ☐ Other: ________________

Please check at least one of the following to indicate what information you would like released to the above individual.

Sage Recovery & Wellness Center, and others listed above, are hereby released from all liability arising out of, or in any way incidental to, producing records or providing information per authorization.

A duplicate, photocopy or facsimile reproduction of this document may be used in lieu of the original.

This authorization is subject to revocation in writing by the undersigned.

Client Signature____Date______________________

Parent/Guardian Signature____Date________________________

Staff Witness Signature ____

Assessment Authorization Form

I,_______________________________________, certify that I understand and agree to the information provided In the following documentation:

- Policies and Miscellaneous Fees
- Group Rules
- Client Bills of Rights
- Client Responsibilities

Client Signature:____ Date:__________________

If the client is under the age of 18, the signature of a parent or legal guardian is required, and such person's signature will certify agreement on behalf of the client.

Printed Name of Parent or Guardian: ____

Signature of Parent or Guardian: ______________________________Date: _________________

Confidentiality Statement

Sage Recovery & Wellness Center is required to provide you with confidentiality and consent information and to obtain your signature to acknowledge that you have read and understood this form.

Those laws require us to treat all contact with you as confidential; this includes phone calls, appointments, and written communication.

Treatment at Sage Recovery & Wellness Center is a voluntary and joint effort. Sage Recovery & Wellness Center staff members are employees of Sage Recovery & Wellness Center and are not directly affiliated with your insurance carrier.

Please note as part of the center's way of protecting your privacy we do not return calls from caller ID. If you would like a return call please leave a message on our confidential voicemail. Even if the request is initiated by you, we also cannot accept requests to be "connected" or "friends" with clients on social media sites as it could breach legally-protected confidentiality. If you see a Sage Recovery & Wellness Center staff member outside of the center, acknowledgment will be left to you in order to respect your privacy. Please note that email correspondence is not a secure method for communication and choosing to do so could result in an unintentional breach of confidentiality.

- I authorize Sage Recovery & Wellness Center to call or send text messages to the **phone number** provided on the **registration form** and to leave a message referencing any items that assist the center in carrying out treatment provided, such as **appointment reminders, insurance items and any calls pertaining to my clinical care**. I understand it is my choice which phone number I authorize consent for.
- I authorize Sage Recovery & Wellness Center to mail any items that assist the practice in carrying out treatment, payment, and healthcare operations (TPO), such as discharge follow up letters and patient statements, to the **address** provided on the **registration form.**

Appointments, Payment, and Insurance

Appointments: All office visits are by appointment and may be scheduled through the front desk staff or your therapist. Consistency is an important part of the counseling process; therefore the appointment time you schedule is reserved for you and is not available to anyone else. Please arrive on time, as you use up your session time when you arrive late for an appointment. The usual length of an appointment is 50 minutes. **If you are unable to keep a scheduled appointment, you must notify Sage Recovery & Wellness Center at least 24-hours in advance to avoid having to pay for the canceled or missed appointment. Please leave a message on our confidential voicemail during non-business hours.**

Cancellation Policies: Since scheduling of an appointment involves the reservation of time specifically for you**, a minimum of 24-hours notice is required for rescheduling or canceling an appointment**. Without 24-hours notice, you will be financially responsible for the full amount of the scheduled session. Most insurance companies do not reimburse for missed sessions. Your compliance in keeping appointments and actively participating in treatment is vital.

Payment: Self pay clients, including those not billing any insurance company or third party payer, are expected to pay in full at time of service unless other arrangements have been made. Except in the case of minors or when other arrangements are made, the individual receiving services is financially liable. I understand additional fees are charged for lengthy telephone communications, court attendance and report/letter writing. Insurance does not cover this.

Insurance: I understand I may be responsible for the remaining balance if the insurance or third party does not cover the full allotted amount. Sage Recovery & Wellness Center will send me an invoice with the remaining amount, which I am required to pay in full within 30 days after the rendering of services. I understand co-pays are expected at the time of service and that co-pays are non-negotiable. Failure to pay your part may jeopardize your insurance benefits. I understand should I become ineligible for insurance coverage, I agree to notify the center and I will be responsible for 100% of the remaining balance. I understand that a re-billing fee/financial charge complying with Texas State Law may be applied to any overdue balance. In the event of non-payment, I will bear the cost of collection, court costs, and/or legal fees should this be required. If services are conjoint (couples or family therapy), all clients 18 and older need to sign this contract due to confidentiality and your individual rights, regardless of who is the identified financially responsible client.