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**NEW CLIENT INFORMATION**

Today's Date: \_\_\_\_\_ SSN/ Driver's License Number: \_\_\_\_\_

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Legal Gender: \_\_\_\_\_ Gender Identity: \_\_\_\_\_ Pronouns: \_\_\_\_\_  
 Sexual Orientation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Email: \_\_\_\_\_

Job (if applicable): \_\_\_\_\_ Employer (if applicable): \_\_\_\_\_

School \_\_\_\_\_ Grade: \_\_\_\_\_

Significant Other:  Single  Married  Dating

Do you have siblings?  Yes  No

If Yes, please list:

Name	Biological, Adopted, or	Current Age	Gender	Lives with you?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Parent Name: \_\_\_\_\_ Parent Name: \_\_\_\_\_

Parents are:  Married  Separated  Divorced  Widowed  Living Together

If separated or divorced, how old were you when the separation occurred? \_\_\_\_\_

Who are you living with currently?  Both parent

One parent (please specify): \_\_\_\_\_

Other (please specify): \_\_\_\_\_

Who has primary custody (if applicable): \_\_\_\_\_

Is there a parenting plan?  YES  NO

Please describe the current visitation schedule (if any) and type of communication with the other parent(s): \_\_\_\_\_



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**HEALTH CARE INFORMATION**

Rate your physical health: Excellent Good Average Declining

Primary care physician: \_\_\_\_\_ Phone number: \_\_\_\_\_

Are you now under doctor's care? YES NO Reason for care? \_\_\_\_\_

Currently taking any medications? YES NO If yes, please specify: \_\_\_\_\_

Do you use any substances? YES NO If yes, please specify \_\_\_\_\_

Do you drink alcohol? YES NO If yes, how often?: \_\_\_\_\_

Have you, or a family member, even been diagnosed with a mental health disorder? \_\_\_YES\_\_\_NO  
If yes, please specify \_\_\_\_\_

**Please answer the following questions:**

What brings you to counseling?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any previous Therapy/ Counseling  Yes  No If yes, describe where, when, how long, and what for?

\_\_\_\_\_  
\_\_\_\_\_

What do you hope to get out of counseling?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Give 3 adjectives to describe yourself:

\_\_\_\_\_

Is there any other information I should know about you?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How did you hear about us? Relative Friend School Doctor/clinic Internet Other \_\_\_\_\_



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### FINANCIAL RESPONSIBILITY INFORMATION

Name of Patient: \_\_\_\_\_ DOB Patient \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip code \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_  
**\*\*Email:** \_\_\_\_\_

#### Primary Insurance Information:

Subscriber Name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: Full  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip code \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_  
Client Relationship to Subscriber: \_\_\_\_\_  
**Name of Insurance Company:** \_\_\_\_\_  
Subscriber's ID# \_\_\_\_\_ Group # \_\_\_\_\_  
Co-pay amount: \_\_\_\_\_ Customer Service Phone # \_\_\_\_\_

#### Secondary Insurance Information:

Subscriber Name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip code \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_  
Client Relationship to Subscriber: \_\_\_\_\_  
**Name of Insurance Company:** \_\_\_\_\_  
Subscriber's ID# \_\_\_\_\_ Group # \_\_\_\_\_  
Co-pay amount: \_\_\_\_\_ Customer Service Phone # \_\_\_\_\_

**Financially Responsible Party Signature** **X** \_\_\_\_\_

Date: \_\_\_\_\_

**Fees** for Clinicians (and Professional Associates) at Ohana Behavioral Health apply as follows: Initial session (55 mins) is billed at \$250; Subsequent sessions (50 mins) are billed at \$200 (PA \$100) for individuals and \$225 (PA \$125) for families. Standard fees apply for 3rd party reports at \$200 per 1/4 hour. The rate for cash paying clients for Clinicians is \$160 per session. Longer sessions may occasionally be called for with fees prorated accordingly. **Payment** is due the same day of service and may be paid by cash, card, or online using the payment option on client portal. **Cancellation Policy:** If you are unable to keep an appointment, please let us know at least 48 hours in advance of your appointment. Otherwise, there will be \$100 late cancelation/ no-show fee. **Managed Care:** Payments made in part of in full by a managed care organization (MCO) require compliance to the regulations of your plan. As your policy is a contract between you and your carrier, it is your responsibility to check with your insurance provider to confirm terms and limitations of coverage. **If your insurance fails to pay, for whatever reason, you are responsible for the full-billed amount.**

# Pediatric Symptom Checklist-17 (PSC-17)

Caregiver Completing this Form: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Child: \_\_\_\_\_

		Please mark under the heading that best fits your child			For Office Use		
		NEVER	SOME-TIMES	OFTEN	I	A	E
1.	Fidgety, unable to sit still						
2.	Feels sad, unhappy						
3.	Daydreams too much						
4.	Refuses to share						
5.	Does not understand other people's feelings						
6.	Feels hopeless						
7.	Has trouble concentrating						
8.	Fights with other children						
9.	Is down on him or herself						
10.	Blames others for his or her troubles						
11.	Seems to be having less fun						
12.	Does not listen to rules						
13.	Acts as if driven by a motor						
14.	Teases others						
15.	Worries a lot						
16.	Takes things that do not belong to him or her						
17.	Distracted easily						
(scoring totals)							

**Scoring:**

- Fill in unshaded box on right with: "Never" = 0, "Sometimes" = 1, "Often" = 2
- Sum the columns.  
 PSC17 Internalizing score is sum of column I  
 PSC17 Attention score is sum of column A  
 PSC17 Externalizing score is sum of column E  
 PSC-17 Total Score is sum of I, A, and E columns

**Suggested Screen Cutoff:**

- PSC-17 - I  $\geq$  5
- PSC-17 - A  $\geq$  7
- PSC-17 - E  $\geq$  7
- Total Score  $\geq$  15

*Higher Scores can indicate an increased likelihood of a behavioral health disorder being present.*

PSC-17 may be freely reproduced.

Created by W Gardner and K Kelleher (1999), and based on PSC by M Jellinek et al. (1988)  
 Formatted by R Hilt, inspired by Columbus Children's Research Institute formatting of PSC-17

# PSC-17 Scoring

The PSC-17 can help primary care providers assess the likelihood of finding any mental health disorder in their patient. The brief and easy to score PSC-17 has fairly good mental health screening characteristics, even when compared with much longer instruments like the CBCL (Child Behavior Checklist by T. Achenbach).

A 2007 study in primary care offices compared use of the PSC-17 to simultaneous use of the CBCL in 269 children aged 8-15, showing reasonably good performance of its three subscales compared to similar subscales on the CBCL. The gold standard here was a K-SADS diagnosis, which is a standardized psychiatric interview diagnosis. These comparison statistics are summarized below, with positive and negative predictive values shown based on different presumed prevalence (5 or 15%) of the disorders. Providers should notice that despite its good performance relative to longer such measures, it is not a foolproof diagnostic aide. For instance the sensitivity for this scale only ranges from 31% to 73% depending on the disorder in this study:

K-SADS	Screen	Sensitiv-ity	Specific-ity	PPV 5%	PPV 15%	NPV 5%	NPV 15%
ADHD	PSC-17 Attention	0.58	0.91	0.25	0.53	0.98	0.92
	CBCL Attention	0.68	0.90	0.26	0.55	0.98	0.94
Anxiety	PSC-17 Internalizing	0.52	0.74	0.10	0.26	0.97	0.90
	CBCL Internalizing	0.42	0.88	0.13	0.38	0.97	0.90
Depression	PSC-17 Internalizing	0.73	0.74	0.13	0.33	0.98	0.94
	CBCL Internalizing	0.58	0.87	0.19	0.44	0.98	0.92
Externalizing	PSC-17 Externalizing	0.62	0.89	0.23	0.50	0.98	0.93
	CBCL Externalizing	0.46	0.95	0.33	0.62	0.97	0.91
Any Diagnosis	PSC-17 Total	0.42	0.86	0.14	0.35	0.97	0.89
	CBCL Total	0.31	0.96	0.29	0.58	0.96	0.89

W Gardner, A Lucas, DJ Kolko, JV Campo "Comparison of the PSC-17 and Alternative Mental Health Screens in an At-Risk Primary Care Sample" JAACAP 46:5, May 2007, 611-618

PSC-17 Internalizing score positive if  $\geq 5$   
PSC-17 Externalizing score positive if  $\geq 7$   
PSC-17 Attention score positive if  $\geq 7$   
PSC-17 Total score positive if  $\geq 15$

"Attention" diagnoses can include: ADHD, ADD

"Internalizing" diagnoses can include: Any anxiety or mood disorder

"Externalizing" diagnoses can include: Conduct disorder, Oppositional Defiant Disorder, adjustment disorder with disturbed conduct or mixed disturbed mood and conduct